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VOLUME 3 • MAY 1948 • NUMBER 5

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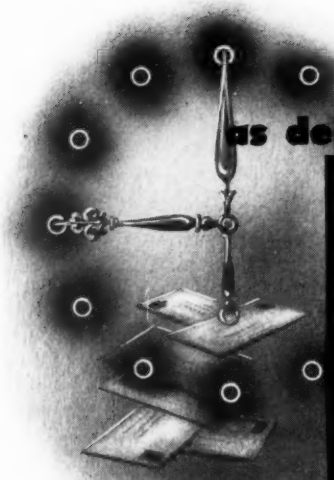

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The Journal of the American Medical Women's Association is not responsible for any statement made or opinion expressed by any of its contributors.

Official monthly magazine of the American Medical Women's Association, Incorporated. Advertising and subscription offices are located at Apt. 3—1517 Center St., Little Rock, Arkansas.

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JOURNAL OF THE AMERICAN MEDICAL WOMEN'S ASSOCIATION is published monthly by the American Medical Women's Association, Inc., at 136 4th Ave., N., Nashville 3, Tenn. Entered as second class matter at the Post Office at Nashville, Tennessee, under the Act of August 24, 1912. Acceptance for mailing at special rates of postage provided for in Section 1102, Act of October 8, 1917, and authorized July 13, 1918.

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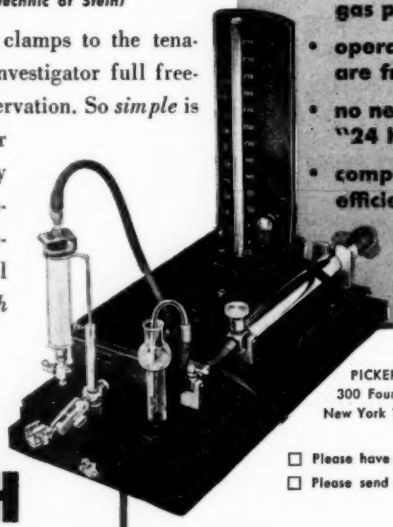

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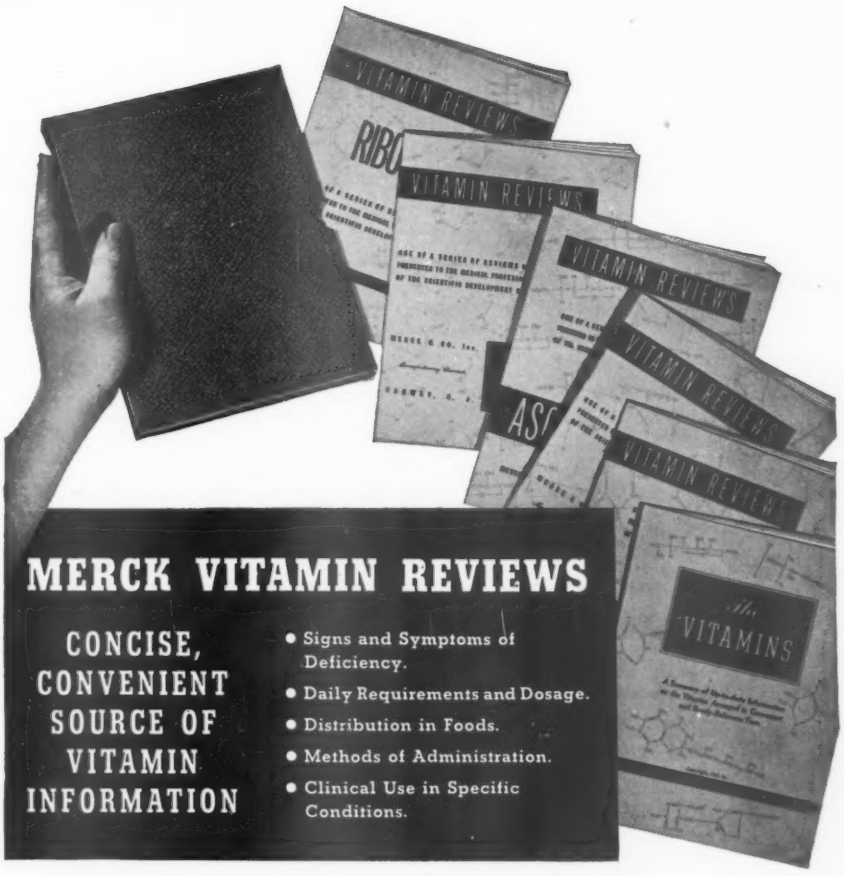

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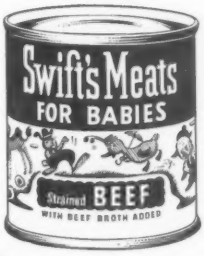

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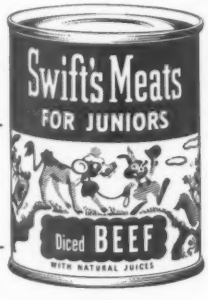

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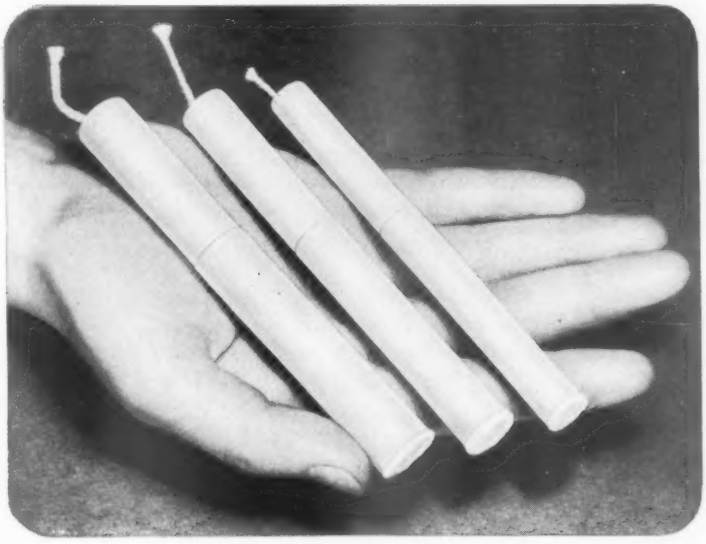

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VOLUME 3 MAY 1948 NUMBER 5

Electroencephalography

Linda T. Schneider, M.D.

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HANS BERGER is generally regarded as the father of electroencephalography, having published his first paper on this subject in 1929. In 1943 Gibbs[1] ventured to predict that "in a few more years the electroencephalogram will not be curious or wonderful, but only familiar and increasingly useful." This enthusiasm was clearly not shared by Bucy in 1945.[2] To present a short discussion on the importance of clinical electroencephalography today is the purpose of this communication.

Origin of Brain Waves: Though electrical fluctuations of the brain have been known to exist, since 1875,[3] recent neurophysiology has developed two divergent hypotheses for the features of cortical activity: the association of neurons (1) by electric fields and (2) by direct neural (dendrites and internuncial neurones) connections.[4] It is not surprising then that the exact mechanisms underlying electroencephalography are not clearly understood. The electroencephalogram is, however, a valid electrophysiological observation. As such it has become an aid of considerable importance in the making of clinical diagnoses.

Technique of Recording: The routine electroencephalogram is obtained through the scalp electrodes. Small, 5 mm. size, solder discs attached to fine flexible wire are applied to the scalp and held in place firmly with collodion. The fine wires are connected to a switchbox, then to a system of amplifiers and to a recording system of 1 to 8 pens moving simultaneously. The number of electrodes and the scalp areas to which they are applied vary with different workers and the purposes they are used for. Through the scalp electrodes, the electroencephalogram records only the electrical activity of the outer convexity of the hemispheres. Recording through the scalp electrodes is the usual technique.

Several special techniques must be mentioned. Recordings from the base of the brain have been obtained by placing an electrode through the nose against the posterior nasopharynx,[5] and from sub-sphenoid, spheno-ethmoidal and subfrontal leads.[6] Intraventricular[7] and cisterna magna[8] electrodes have been described. Penfield and Jasper have had extensive experience with electrodes applied directly to the cortex of their neurosurgical patients.[9] Activated electroencephalography is a special technique used for a more accurate localization of cortical lesions producing post-traumatic epilepsy. With this technique the abnormal cortical foci are "activated" by a drug, such as metrazol, to produce alterations in the electroencephalogram.[10] Electroencephalography in restless infants and children is complicated by their failure to sit or lie quietly for the length of time required to take a record. To overcome this electroencephalograms were obtained when the patients were under pentothal anesthesia.[11]

Apparatus: The Grass electroencephalograph, an ink writing machine with variable recording speeds, is preferred by most electroencephalographers. Various instruments by Garceau, Rahm, Medcraft and the Electrophysiological Labs produce records of different appearance. Comparisons of such records are very difficult. Very recently Cohn[12] published his two precision methods for taking electroencephalograms: (1) by connecting the Grass electroencephalograph to an electronic switch operating into a cathode ray oscilloscope, and (2) by operating 2 or 3 channels of the Grass electroencephalograph machine into a triple-gun cathode ray oscillograph.

There exists an obvious need for the standardization of the electroencephalographic apparatus and the recording techniques. This will become one of the earliest tasks of the American Association of Electroencephalographers.

Analysis of Electroencephalogram: Routine

analysis of the electroencephalographic tracings are made by visual inspection of wave forms, frequencies and amplitudes, and the results compared with the cortical frequency spectra[13] which have become the accepted clinical standard. Several manual and mechanical analyzers have been prepared for the interpretation of the electroencephalographic problems.[14,15,16] None of these is altogether satisfactory.

Normal Electroencephalograms: Continued rhythmicity is characteristic of the human brain, judged by its electrical effects. The most prominent normal rhythm as recorded through the scalp appears as a series of smooth sinusoidal waves from the parieto-occipital regions with a frequency of 8-12/sec. and an amplitude of 20-60 millivolts, generally called the alpha rhythm. The alpha rhythm can occur only when the disturbing influences of afferent stimulation are excluded. During the recording of an electroencephalogram, therefore, the patient should sit relaxed, with eyes closed in a quiet room. When afferent stimuli are admitted (flickering light, noises, etc.) the alpha rhythm is broken up and the cortex begins the irregular, heterogeneous activity which is presumably necessary for discriminative behavior.

From the anterior head regions the normal frequencies are the 18-32/sec. waves, called the beta rhythm, with lower than the alpha amplitudes. The 1-7/sec. waves are called the delta waves, and these have higher than alpha amplitudes. Normally the delta frequencies are found in the electroencephalograms of children under 12 years of age, during sleep; and abnormally in a large number of pathological functional states of the cerebral cortex. Normally the frequencies recorded from bilaterally homologous areas of the hemispheres are highly synchronous and of equal amplitudes. (*See illustration and legend.*)

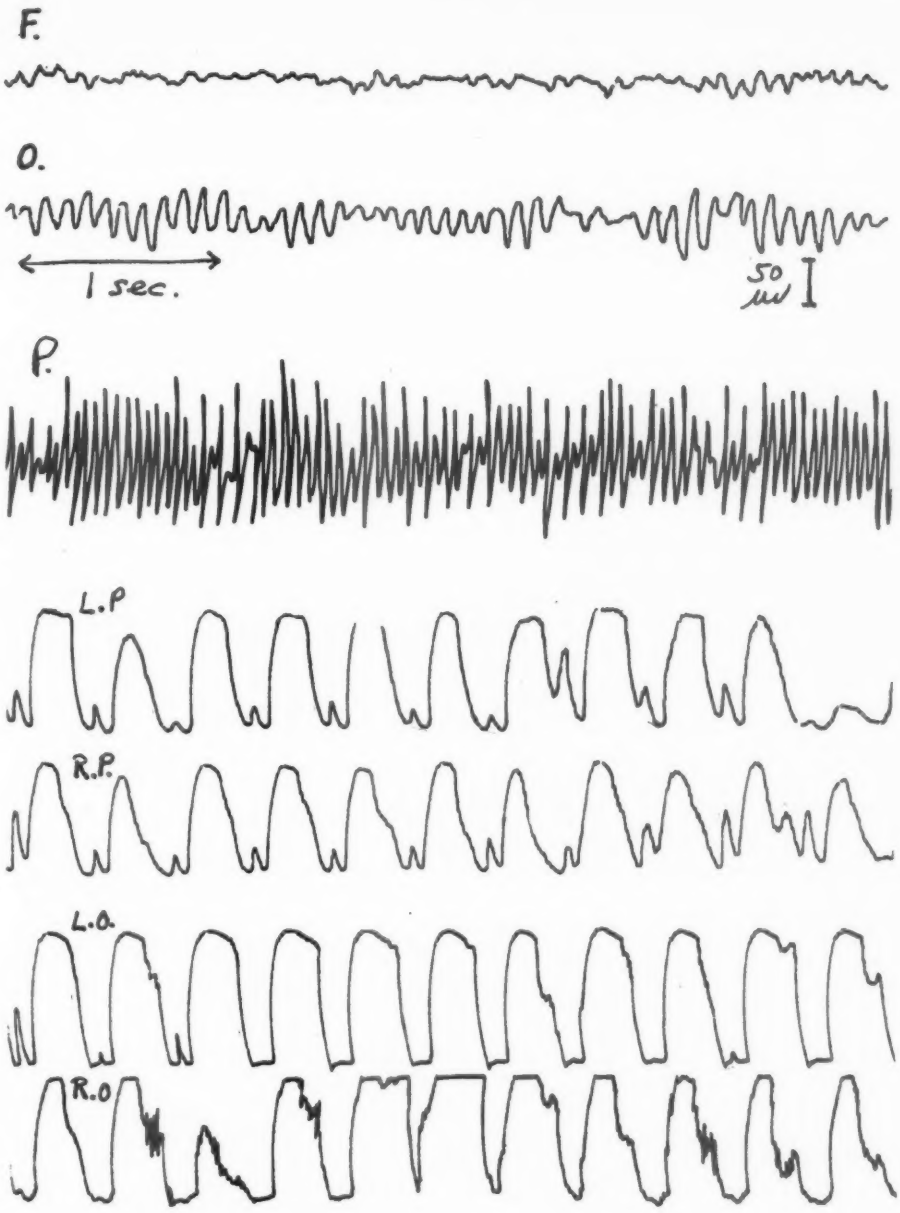
Abnormal Electroencephalograms: An electroencephalogram is labeled abnormal if it shows evidence of dysrhythmia or hypersynchrony. Abnormal cortical frequencies are called cerebral dysrhythmias.[17] These may be made up of random, paroxysmal, slow or fast types of waves. Spikes are random waves of about 0.02 sec. in duration. Sharp waves are like spikes, but of a somewhat greater duration due to a prolonged descending phase. Almost any frequencies may occur in paroxysms but the following ones are the more common: (a) 2/sec. wave and spike, (b) 3/sec. wave and spike, (c) 3/sec. waves, (d) 4-6/sec. flat topped or saw-toothed waves, (e) 14/sec. waves and (f) 25/sec. waves. Hypersynchrony signifies waves of abnormally high amplitudes. Hypersynchrony is usually associated with dysrhythmias but may occur independently.

Clinical Electroencephalography: In discussing diseases and clinical entities associated with cerebral dysrhythmias it will be convenient to divide the dysrhythmias into 3 groups: (A) Paroxysmal (B) Localized (C) Generalized.

A. Hans Berger was the first to demonstrate that a clinical epileptic attack was accompanied by very large electrical discharges of the brain. The relationships between the paroxysmal abnormal cortical potentials and clinical epileptic seizures were classified by Gibbs, Gibbs, and Lennox.[13] Since that time it has become accepted clinical practice to speak of the idiopathic epileptic seizures in terms of certain types of seizure wave patterns proposed by these workers: (1) Grand mal type, fast 12-35/sec. wave discharges of increased amplitude; (2) Petit Mal type, alternating 3/sec. wave and spike pattern; (3) Petit Mal Variant, alternating 2/ sec. wave and spike pattern; (4) Psychomotor type, 4-6/sec. flat topped waves. This classification has certain distinct clinical advantages. It helps to differentiate the idiopathic or cryptogenic epilepsies (without known pathological alterations of the brain) from the symptomatic epilepsies (due to demonstrable lesions of the brain) electroencephalographically.

From the more superficial symptomatic epileptogenic lesions appear localized random spikes and sharp waves. If and when the localized abnormality is severe enough these spikes and sharp waves may spread to other regions of the cortex. From the deeper focal cortical epileptogenic lesions, however, spikes are not recorded. Lesions on the inferior surfaces of the brain in the anterior or middle fossa, those on the inferior surfaces of the temporal lobes, and those on the mesial surface of the brain within the longitudinal fissure often produce bilateral disturbances in the electroencephalogram which are extremely difficult for the encephalographer to interpret correctly. Localization of the deeper cortical lesions through the scalp electrodes is not nearly as reliable as it is for the superficial ones. Lesions in the midbrain, thalamus, or basal ganglia may produce bilateral rhythmic disturbances which may simulate wave patterns usually associated with the idiopathic epilepsies.

Recently a new "Epileptiform syndrome" has been described.[18] This epileptiform syndrome occurred in patients with essentially negative neurological findings who suffered from such symptoms as cranialgia, emotional instability, vasomotor instability, loss of consciousness, impaired conscious-



F. *Frontal lead showing low voltage beta waves*

O. *Occipital lead with rhythmic alpha (10 /sec) frequencies.*

P. *Parietal lead recording of a grand mal seizure.*

LP., RP., LO., RO., *left and right parietal and occipital leads showing the alternating spike and 3 /sec slow wave configuration of a petit mal seizure.*

ness, personality disorders, and epilepsy. In these patients the electroencephalogram was within the broad normal limits but showed a high incidence of related alpha (10 per second) frequencies and flat topped psychomotor waves which they called alpha variants. The half and the double alpha variants appeared as the common electroencephalogram component in this syndrome. The term psychomotor epilepsy used in the past was considered inadequate by this author to describe the entire range of psychic variants included under the term epileptiform syndrome. Thus our conception of the limits of epilepsy has been enlarged to include many disorders of behavior and thinking: such as psychotic, psychopathic, psychoneurotic behavior, emotional outbursts, confusional and compulsive states, previously classified as "fugnes" and "epileptic equivalents"[8] and "automatisms."[9]

B. Localized cerebral dysrhythmias are caused by a variety of etiological factors. Jasper and associates[10] first correlated asymmetry of amplitudes in the electroencephalogram with subdural hematoma. Cerebral abscess, edema, hemorrhage, laceration, aneurysm, thrombosis, and tumors were soon added to the list,[3] the last being porencephaly.[20] The exact localization of tumors of the anterior and middle cranial fossae electroencephalographically is the procedure of choice at the present time with most neurosurgeons. At times electroencephalography has accurately localized a frontal lobe tumor, for instance, when pneumoencephalography has failed to show its presence. With tumors of the posterior cranial fossa, on the other hand, the electroencephalographic localization is far from being reliable. Rheinberger and Davidoff[2] conclude, in fact, that there is no pattern of electrical abnormality specifically indicative of posterior fossa disturbances.

There are a few reports about electroencephalographic changes in the prefrontal lobotomy patients. The most consistent abnormality appears in the frontal regions, but in some patients a generalized dysrhythmia appears. This is not surprising when one considers that most of these patients traded their functional psychoses for organic lesions. In general there seems to be no correlation between the electroencephalographic findings and the post-lobotomy improvement in the patients.[23]

C. The generalized cerebral dysrhythmias may be caused by infections and degenerative diseases of the brain, by pathologic alterations in the general metabolic state of the organism, and normally in the records of infants and young children. Some of the greatest abnormalities seen in electroencephalogy are found in patients with encephalitis.[22] In the acute stages slow waves with very high voltages are found. In the subacute and postacute stages the electroencephalographic pattern is similar to that found in head injuries in which practically all patients show abnormal electroencephalograms initially. But with the passage of time the electroencephalograms of those who are not going to have clinical seizures gradually tend to return to normal, whereas the electroencephalograms of those who are going to develop seizures either remain abnormal or, after slight improvement, will become increasingly abnormal. Convulsions are a much commoner post-encephalitic symptom in children than in adults. Encephalitis and meningitis, if severe enough, will produce definite generalized electroencephalographic abnormalities. Such diffusely abnormal wave patterns are seen also in patients with arteriosclerosis, Schilder's Disease, Pick's Disease, in deteriorated epileptics, and in cases of drug poisoning. Any serious alterations in the normal metabolic state of the body will also produce diffusely abnormal electroencephalograms, as in sleep, uremia, hypoglycemia, cerebral anoxia, acapnia, and following electroshock treatment.

Immediately following electroshock therapy there is a generalized slowing of the electroencephalogram frequencies which bears no relationship to the clinical state of the patient. The electroencephalographic changes produced by treatment are largely reversible.

In the electroencephalograms of newborn babies only low voltage, irregular, slow waves appear. With increasing age the occipital alpha activity becomes more and more prominent[24] until the electroencephalogram assumes adult characteristics at about 14-18 years.

Value of Clinical Electroencephalography: The clinical application of electroencephalography is complicated by the wide range of individual patterns found in any series of normal controls, and by the fact that almost all brain wave patterns which might be used for diagnosis of abnormalities can be found in the electroencephalograms of symptom-free persons. These persons have the "abnormal normal electroencephalograms" found in 10-15 per cent of the normal population at large. Whether this group represents an inherited latent "susceptibility," or whether in these persons there had been some unrecognized brain injury or infection remains unanswered.

While it is true that the electroencephalogram

cannot make a clinico-anatomical diagnosis, it has become an important diagnostic aid which weakens or supports clinical diagnoses. It is an almost indispensable aid in the modern classification, diagnosis, and treatment of the epilepsies. It helps to localize brain tumors, hematomas, and injuries. It serves as a differential diagnostic aid in making the diagnosis between hysterical convulsions and true idiopathic epilepsy. The electroencephalogram has considerable medico-legal importance. In head trauma and postencephalitic epilepsy it becomes a prognostic aid.

In addition the electroencephalogram is also a sensitive indicator of subclinical (larval) epileptiform discharges, a method of demonstrating the genetic predisposition in relatives of epileptic patients. It is a visible record of the spread of an epileptiform disturbance from one brain area to another. With each year electroencephalography has become increasingly useful in child as well as adult psychiatry.

Summary: The electroencephalographic machines and various recording techniques were discussed. The normal frequencies and amplitudes encountered in electroencephalography were presented, followed by a discussion on the clinical application and value of the electroencephalogram in different diseases.

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The Role of Sex Hormones in the Pathogenesis and Treatment of Cancer

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THERE EXISTS some confusion in the minds of physicians as to the role estrogens and androgens play in carcinogenesis and their effectiveness in the treatment of cancer and other malignant diseases. In the following the author reviews the experimental work which proves the carcinogenic tendencies of estrogens under certain conditions in animals, and presents the inconclusive observations of the role they play in cancer in the human. While knowledge derived from animal experiments is of extreme value, nevertheless great caution is necessary in interpreting it as applied to the human.

The early work followed three lines of investigation,[1,2,3,4] conducted independently over several years, and led to the conclusion that a close relation in chemical constitution as well as in biological effects exists between estrogenic hormones and certain hydrocarbons occurring in tar and shown to be capable of producing cancer in mice. The facts which resulted in the formation of this problem came in part from the investigations of Kennaway, Cook, and Dodds and their collaborators concerning the chemical structure of the carcinogenic* constituents of tar and the ability of these and chemically related substances to induce estrus; and in part from other experiments which showed that estrogens are factors in the development of certain kinds of cancer in animals. The stimulus, whether of exogenous or endogenous origin, provokes definite cytological change in the cellular division which characterizes malignant growth, resulting in a loss of subordination to the rhythm of division without any known means of reestablishing cellular order.

*According to Dodds, the term 'carcinogen' should be restricted to those compounds which produce cancer when painted on the skin of mice over a long period. It is used here in its broader sense.

Investigations

(a) Briefly then, Yamagiwa and Itchikawa in 1915 demonstrated that long continued application of tar to a rabbit's ear may initiate cancer; subsequently, Tsutsiu demonstrated that mice were more susceptible than the rabbit to formation of cancer from tar application. Further studies isolated and identified the active substance as a polyhydrocarbon; later it was synthesized and proved chemically identical with those substances extracted from tar and having carcinogenic properties. The chemical relationship between these hydrocarbons and biological substances such as cholesterol, bile acids, ergosterol, Vitamin D, testicular and ovarian hormones, was pointed out by Cook and his associates. From this stemmed the postulation of Kennaway and Cook that under some conditions of local interference sterols in the body might lead to cancer.

(b) The second series of investigations dealt with the analysis of the mechanism and hormonology of the menstrual cycle and the chemical structure of the hormones. A finding by Aschheim and Hohlweg, that extracts of bituminous material (coal—mineral oil) have estrogenic potency and can induce active cell proliferation, led to the assumption that under certain conditions estrogenic substances may induce or accelerate cancer formation.

(c) The third series of investigations under Cori, Murray,[5] and others,[6,7] dealt with the significance of ovarian hormones in the production of mammary cancer in different strains of mice under different conditions, i.e., age, color, strains, rapid forced breeding, etc., and they concluded from their experiments that mammary cancer development in mice depends on the interaction between hereditary factors, which act as sensitizers

of tissues, and ovarian hormones acting as stimulants of tissue growth; that estrogenic substances acting in association with hereditary factors may be strongly carcinogenic, however, restricted in action to tissues in which they (the hormones) induce growth processes during the normal sexual cycle. Recently Bittner** added a third factor, the milk 'agent' (virus) present in the milk of a high tumor strain mouse mother, which is essential to the development of mammary cancers, in addition to the hereditary factors, and the presence of ovaries or their substitute secretion. The suckling (once only) of newborn females of a low tumor strain on a high tumor strain mother significantly increased the incidence of cancer of the breast in these sucklings. A reduction in rate was noted if the situation was reversed.

The Role of Male Hormones

Murray[5,6,7,8] then introduced male hormones into the female mouse through experimental parabiosis, upsetting her sexual cycle and resulting in either a precocious or a prolonged production of graafian follicles which degenerated within the gland without the formation of a corpus luteum. Since none of these females developed mammary tumors it seemed logical to presume that the luteal fraction of the ovarian hormone in some way influenced tumor formation. On this hypothesis the observed difference in the cancer incidence between breeding and virgin females may be explained as due to the prolonged luteal phase of pregnancy, and this is supported by the observations of Lacassagne who found a correlation between the rapidity of normal estrous cycles and the incidence of cancer in mice.

Nathanson and Anderwoort,[9] and others by injecting testosterone in oil found a definite decrease in the incidence of spontaneous mammary cancer in a highly susceptible strain. This decrease is presumably due to an antagonism to the estrogens and/or an inhibiting effect on the pituitary gland (on the gonadotropic factor) which eventually results in ovarian atrophy. The estrogens were further implicated by the work of Lacassagne,[10] who demonstrated cancer in the male of a strain in which only females were affected, by the long continued use of estrogens; and Gardner and his co-workers likewise produced cancer in the breasts of male mice of a high tumor rate strain by injections of large doses of estrogens in oil.

Therapeutic Uses of Hormones in Cancer

Charles Huggins and others[11,12] pointed out that cancer of the prostate is stimulated by the injection of male sex hormones and is inhibited by reduction of androgens either through orchiectomy or by neutralization through administration of female sex hormones. In addition, they observed that decreasing the activity of the androgens either through castration or through the administration of estrogens (diethylstilbesterol) 5 mg. daily, often caused a decrease of serum acid phosphatase values towards normal, whereas the injection of 25 mg. testosterone daily increased these values.

In a recent article Huggins and Johnston differentiated prostatic cancers into those which are androgen dependent and those which are androgen independent, and the failures following treatment, or the relapses after remission, mostly fell in the latter group (androgen independent). In reviewing this work one gathers that the authors place surgical castration in first place for most patients as a basic treatment in advanced or metastatic cancer of the prostate, reserving chemical castration by estrogen treatment for (1) those who refuse surgical castration; (2) a small percentage of patients in whom diagnosis is doubtful; (3) certain feeble men until the condition of the patient improves; (4) cases of relapse or failure following orchiectomy (which failure may be endocrine in nature, as in the production of androgens in the adrenal cortex).

In mammary cancer testosterone therapy[12,13,14] is beneficial in cases with bone metastases, regardless of the age of the patient, or following surgery or when surgery is too great a risk. The dosage recommended is 100 mg. three times weekly for ten weeks, followed by 60 mg. of oral testosterone daily for ten weeks. One precaution must be observed, i.e., blood calcium levels should be followed; if blood calcium is high at the outset and does not decrease, or if it increases, the treatment must be discontinued (danger to the kidneys). The results are variable, but when favorable offer definite relief from pain, increase in appetite, gain in weight, decrease in use of narcotics, and renewed optimism.

Comments

The mammary glands being part of the female genital system are subject to hormonal stimulation, as are the other organs of reproduction, and in

**Bittner, John J. (Roscoe B. Jackson Memorial Laboratory, Bar Harbor, Maine) and collaborators advanced the theory of an extra-chromosomal influence in the transmission of mammary tumor susceptibility.

some indirect manner, not clearly understood, to the nervous system which may initiate the elaboration of hormones. In addition, breast changes may be altered or initiated by excessive stimulation or by increased sensitivity of the tissue involved, which in turn may be linked to heredity, race, color, or constitutional type, causing or altering the metabolic status of the host. This change in the metabolism, due perchance to defective function of the liver, may release abnormal quantities of estrogens or may produce atypical hormones, which may have carcinogenic tendencies. This is possible since steroid hormones are closely allied to several of the known synthetic carcinogens. It is also conceivable that carcinogenic agents from hormones may occur as a result of a faulty metabolism due to change in the physiologic state of the host.

Conclusion

Evidence exists to indicate that endocrine factors are associated with some human tumors, yet there is no conclusive proof that these influences are directly concerned with cancer. It is likelier that as a result of excessive stimulation or atypical metabolism the tissues of susceptible persons are conditioned to the action of a carcinogenic agent. The therapeutic value of hormones in cancer is palliative and should supplement rather than replace surgery.

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The Premarital Consultation

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THE PREMARITAL CONSULTATION is unfortunately still regarded by many members of the medical profession as simply a routine blood test to meet the requirements for a marriage license. It is the purpose of this discussion to try to rectify this attitude and present a plan of premarital counseling.

If possible, I like to see the couple about four to six weeks prior to marriage. This allows time for adequate preparation before the last minute rush. On the first visit the man and woman are interviewed briefly together with an attempt to evaluate their situation and explain the general aspects of the service. A brief history of their background, their relationship to their families, what they expect from marriage, etc., is obtained. In this way, a great deal of information can be gained in an unobtrusive manner. It is very important on this initial visit to obtain rapport with the couple and win their confidence.

Next, each is interviewed alone and most of the counseling is accomplished in these individual interviews. In talking to the woman a brief medical history is obtained to ascertain her general health. The menstrual history is important and should be elicited in detail. The amount of sex instruction necessary will, of course, depend upon the individual. It has been my observation that even the girl who feels very well-informed and self-confident still has much to learn and often many ideas to be corrected. A review of genital anatomy, initial penetration, techniques of intercourse including a discussion of foreplay, orgasm, the postcoital satisfaction is presented. Models and charts are used to illustrate. The plans for children are discussed and the various contraceptive techniques are explained. I strongly advocate that at least a few months and preferably a year after marriage elapses before pregnancy is undertaken. Of course, individual circumstances may alter this advice. If there is no religious objection to the use of mechanical contraception, the diaphragm pessary combined with the use of a reliable contraceptive jelly or cream is my method of choice. There is usually no difficulty in satisfactorily fitting the patient for this before marriage and it is highly desirable.

Next a routine thorough pelvic examination is done. This brings up the question of dilatation of the virginal introitus. In my experience some degree of dilatation is necessary in about 75 per cent of such cases. The widespread use of intravaginal tampons during menses has simplified the job. The dilatation can in almost every case be accomplished by gentle digital stretching without tearing, severe pain, or bleeding, if the necessary time is taken. Surgery is almost never required and in most cases causes an unnecessary psychologically traumatic experience. Before dilatation is started, it is carefully explained to the patient with the reasons for its desirability, then the decision whether or not to have it done is left up to her. I feel that the fact she is making the choice has an important psychological effect. In almost every case, the patient elects to have it done. In the rare instance where there is a strong aversion to it either on the part of the woman or the man, the subject is dropped and the woman is advised to return after marriage if a diaphragm pessary is desired. As the stretching is being accomplished, the woman is taught her own intravaginal anatomy by digital examination of herself. This is essential for subsequent intelligent use of the diaphragm pessary and even when no contraception is desired, it is an important step in dispelling fear or squeamishness of the sexual organs. In addition it occupies the patient's attention and much of the job of dilatation is being accomplished simultaneously. The patient complains much less about discomfort inflicted by herself!

I do not feel that dilatation has to be complete

before a diaphragm pessary can be fitted. It is my practice to do the initial fitting on the first visit if possible. This can usually be done easily as soon as the introitus admits two fingers and often before an adequate pelvic examination is attempted. This then allows time for the patient to familiarize herself with the technique, returning for a check. In addition, I have found that practicing the insertion of the diaphragm is one of the easiest and least painful ways to accomplish further introital dilatation. However, the patient is also urged to continue digital dilatation. Occasionally if the introitus is very small and resistant it is preferable to have the woman see what she can accomplish by self dilatation for a week before fitting is attempted. This is especially true if there is ample time before the marriage date. Also, if the patient is very disturbed emotionally by the examination, it is well to delay the fitting to a subsequent visit.

It is not the purpose of this paper to go into detailed discussion of the diaphragm pessary technique. I think it is generally agreed that the diaphragm pessary must be used in conjunction with a good spermaticidal jelly or cream and left in place a minimum of a few hours after intercourse to accomplish the desired result. I have found the coiled spring type of diaphragm pessary satisfactory for most patients. I prefer digital introduction to the mechanical insertors except in a rare instance. The patient has a clearer idea of what she is doing when she uses her own hands and there is less danger of trauma. When the cervix points anterior as in cases of retroversion and some cases of anteflexion there is sometimes difficulty in placing the diaphragm pessary. I have found the flat type of spring or the Bow Bend Durex diaphragm very helpful in such cases. By virtue of the spring they can be inserted in a more posterior direction and the cervix avoided.

At the time of the first fitting of the diaphragm pessary I like to explain in detail the instructions for its use. This includes a discussion of douching, which as far as I am concerned has nothing to do with protection and is not necessary for personal hygiene. Its desirability varies with the individual. If the patient has never douched the proper technique is explained and she is advised to practice this too. In this way, the patient has time to assimilate all that she has been told and the technique can be reviewed and any questions she may have thought of answered when she returns for her check visit.

During and after the pelvic examination, there is a chance for further discussion. In fact I like to do the examination as early in the interview as is feasible. Most patients who have never been examined before have a preconceived dread of the experience and after it is finished they are greatly relieved, much less tense and more at ease. Furthermore some of the instruction in anatomy is best done at the time of examination and then the patient is better prepared for discussion. A complete physical examination is always advisable if time and economics permit and should certainly be done if any indication is obtained from the medical history.

An interpretation of her role in the sexual relationship of marriage is given. She is impressed with the fact that intercourse is a privilege not a duty and that she should expect to enjoy it. However, it is emphasized that the ideal relationship is achieved by a process of gradual co-operation. It is also important to determine the patient's attitude toward child bearing. Although pregnancy at a later date is usually desired, it is commonly feared due to ignorance. Often, a brief discussion of the physiology of pregnancy is helpful. If the woman volunteers that she has had previous sexual experience I feel that this should be discussed to determine the presence of a guilt reaction and eradicate it if possible. If the occurrence of previous intercourse is obvious, but not admitted or even denied, it is a matter of judgment as to whether the subject should be pursued. The same applies to masturbation.

The same general plan is followed in the interview with the man alone. He is questioned carefully about factors which might affect his fertility, such as venereal disease, mumps affecting the testes, undescended testes, etc. The external genitalia are examined and if there is any reason to doubt fertility a semen test should be done. As in the case of the woman, a complete physical examination is ideal and should be done if indicated. His general attitude toward sexual matters, previous sexual experience, masturbation, and similar problems are discussed. If introital dilatation is deemed advisable for the woman, this is explained to the man along with a discussion of the initial penetration, techniques of intercourse, early sexual adjustments, etc. When the diaphragm pessary method of contraception is to be used, I feel that it is important to explain the general principles to the man so that he will be understanding and co-operative. Likewise, if the con-

dom method has been elected, it is well to see that he understands its proper use.

At the time of the initial interview, I like to assign reading. Of the various manuals, I have found the book, *Marriage and Sexual Harmony,* by Dr. Oliver M. Butterfield very helpful for routine use. It is brief, to the point, and nicely presented. Obviously, however, the reading to be recommended will vary with the individual requirement. I strongly advise the couple to do the reading together. This insures a common source of information and often provides the stimulus for frank discussion between them. They are also thus furnished with a vocabulary—so often a couple is willing and eager to discuss the subject in a natural way, but are at a loss for words to express themselves. If questions arise they are urged to write them down for discussion at the subsequent visit.

As mentioned before, it is advisable to have the couple or at least the woman return for a second visit before marriage if possible. This is particularly important if the diaphragm pessary is to be used. The patient is checked to see if she has inserted the diaphragm pessary correctly, whether the correct size has been issued and the technique of its use understood. Opportunity is provided for further discussion of any problems or questions. It is again emphasized that sexual adjustment takes time—usually weeks or months. They are reassured and urged not to anticipate any problems. And finally, they are counseled to seek help early if they feel they are having difficulty after adequate trial of their own resourcefulness.

Too many young people get married without the background and understanding which is necessary for a successful marriage. Most young couples today are eager and anxious for advice, but they do not know where to seek it. Their parents are usually unable to help them and the family doctor is often too busy or not interested in this work. It seems to me that we, as women physicians, can make a real contribution in this much needed field; in general most of the time is spent with the woman and she is usually greatly relieved to be able to talk to someone of her own sex.

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DECLINE IN MORTALITY FROM TOXIC GOITER

Distinct progress has been made in recent years in reducing the mortality from toxic goiter. Among the Industrial policyholders of the Metropolitan Life Insurance Company the adjusted death rate from this cause at 1 to 74 years declined from 1.9 per 100,000 in 1940 to 1.1 in 1946, a reduction of more than 40 per cent. This favorable experience is particularly noteworthy because for a decade prior, the death rate showed little improvement, fluctuating about an average of 2.4 per 100,000. The trend among these insured persons parallels that for the general population of the United States.

The recent decline among the policyholders favored each color and sex group. Special interest attaches to the very material reduction in mortality at each age period among women, among whom the deaths from toxic goiter are largely concentrated. Few diseases exhibit such large excess of mortality among females as compared with males.

In view of the geographic variation in the death rate from toxic goiter, it is pertinent to examine the trend in the individual States. Table 2 shows the average death rates in the general population for the periods 1939-1940 and 1944-1945. Almost all the States shared in the improvement in mortality, the largest relative decreases being recorded generally in the States with the highest death rates from the disease—the region surrounding the Great Lakes and parts of the Rocky and Appalachian Mountains. For example, Ohio and Indiana, which are in the center of the "goiter belt," registered declines of 35 per cent and 55 per cent, respectively, in the five-year period under review. Pennsylvania, Minnesota, Illinois, Michigan, Idaho, all with above-average death rates, registered reductions of at least 30 per cent.

Data are not at hand to indicate whether the recent decrease in the mortality from toxic goiter has been due to a reduction in the incidence of the disease, or to a lowered case-fatality rate. It appears, however, that the last-mentioned factor is the more important. Certainly, recent years have witnessed marked advances in the medical treatment of thyroid conditions. Moreover, in the cases where surgical intervention is required, the risk has undoubtedly been appreciably reduced. Not only has there been an improvement in diagnostic technique and surgical skill, but there has also been a wider use made of chemotherapy to combat the infections, particularly pneumonia, which may follow surgery.

In 1945 there were 2,468 deaths from toxic goiter in the general population of the United States as compared with 3,659 in 1940. There is good reason to expect that further progress against the disease will be effected in the immediate future.—*Statistical Bulletin,* Metropolitan Life Insurance Co., November 1947.

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Peritoneoscopy

Elizabeth T. Endicott, M.D.

PERITONEOSCOPY is a procedure which is now being used frequently as a diagnostic aid. In properly selected cases much can be learned that will be of benefit to the patient with very little discomfort to him, and more traumatizing procedures may be found to be unnecessary.

The first view of the abdominal contents through a scope was made by Kelling in Germany in 1901. He used a cystoscope and worked with dogs. In 1911 Bernheim at Johns Hopkins introduced a proctoscope with one half inch bore into the epigastrium and using a head mirror examined the stomach, liver, gallbladder, and diaphragm.

Ruddock in California is largely responsible for the revival of interest in this country and has perfected the instrument that is in general use today. In 1937 he published a report on 500 cases in which the average clinical accuracy of diagnosis was 61 per cent while the average accuracy with the peritoneoscope was 91.7 per cent.

Peritoneoscopy may be considered almost entirely a diagnostic procedure. It affords a very simple method of looking into the interior of the abdominal cavity at the surfaces of the viscera and peritoneum. Through its use a great many purely diagnostic laparotomies can be avoided. That this is of considerable value is easily evident from a comparison of the two procedures. A laparotomy, being a major operation, necessitates considerable preoperative preparation, such as fluids, correction of malnutrition, transfusions, etc., and requires that the patient be hospitalized ten days to two weeks. (This is of economic importance.) It requires a general or spinal anesthetic and a large incision. Following laparotomy there is considerable discomfort to the patient and dietary limitations are necessary for several days. Mortality rate varies from 2 to 6 per cent depending upon the clinic.

Peritoneoscopy, on the other hand, is a minor procedure requiring no preoperative preparation. It is done under local anesthesia through an incision about 3/8 inches long and requires hospitalization of only one day. The mortality rate is very low, about 0.2 per cent. The entire preoperative preparation used by us is a soapsuds enema accompanied by 0.5 mg. of prostigmine subcutaneously, abdominal preparation, if necessary, and withholding the meal just before the procedure. Sodium phenobarbital, 0.1 gm., and morphine sulphate 0.016 gm. are given a short time before examination. Ideally the peritoneoscopy should be done with the patient prepared for laparotomy if the findings indicate that laparotomy may be of benefit. For instance, in a case of known carcinoma of the stomach, peritoneoscopy should be done first to determine the presence or absence of liver metastases. If these are not found to be present, laparotomy is indicated and may follow immediately. If metastases are present, the patient has not been subjected to the added discomfort of needless laparotomy.

After peritoneoscopy with liver biopsy, codeine may be required for pain for 8 to 12 hours. The patient is allowed a soft diet the rest of the day and no dietary restrictions are necessary thereafter.

The Instrument and Procedure

The Ruddock peritoneoscope is the one in general use today. It consists of a pneumoperitoneum cannula and trochar which are introduced first. The cannula has a bore of about ⅛ inch and is equipped with a sliding collar and set screw to govern the depth of penetration, minimizing the danger of penetrating underlying structures. Air is introduced with an insufflation bulb until the abdominal wall is fairly tense and is lifted away from the underlying viscera. With air beneath the peritoneum it is easy to locate the peritoneal surface with a needle and to anesthetize this surface with a few cc. of 1 per cent procaine. This is an important step in adding to

the patient's comfort during the procedure and of gaining satisfactory co-operation from him.

A larger cannula and trochar with a diameter of about ⅜ inch is then introduced and the air space can be maintained through which abdominal viscera can be viewed. All of the other parts of the instrument are introduced through this larger cannula.

A perforated tube for the removal of ascites is provided. The examining telescope is about 10 inches long, adequate to reach all parts of the abdominal cavity. The lens is on the side allowing vision that is forward and oblique to an angle of about 55°. By rotating the telescope on its own axis it is possible to see above, below, and to either side in one position, and by turning the whole instrument with the abdominal incision as an axis, all four quadrants of the abdomen can be reached. Vision of the various portions of the abdomen can be facilitated by tilting the table so that the part to be viewed is uppermost. To view the liver, spleen, stomach, and diaphragm, the head of the table is raised. Paracentesis is done most effectively in this position. View of the pelvis is best made in the Trendelenberg position, and manipulation of the pelvic organs through the vagina make it possible to see these to much better advantage. By tilting the table to either side a better view of the spleen, sigmoid, or appendix can be obtained.

The instrument also includes a biopsy forceps equipped with its own lens system and cautery to prevent subsequent hemorrhage. A Levine tube with light allows transillumination of the stomach.

The site of incision may be anywhere depending upon the particular portion of the abdomen to be viewed or upon positions of previous incisions which may have adhesions to the under surface to interfere with a view of the portion desired. The most common sites of incision are in the midline a little below or above the umbilicus.

Structures visible and not visible

Most satisfactory view is obtained of the liver and probably 75 per cent of peritoneoscopies are done to view this organ. The entire upper surface the edge, and a considerable portion of the lower surface are easily seen. Clinically diagnosis of the cause of enlarged liver is not always easy. With the peritoneoscope cirrhosis may be easily distinguished from carcinoma, either primary or metastatic, with liver biopsy as part of the procedure, which is of great diagnostic aid.

Other structures usually seen are the under surface of the diaphragm; the anterior wall and greater curvature of the stomach, particularly with transillumination; the small intestine; the colon except for the sigmoid; the dome and posterior surface of the bladder, and the parietal peritoneum. The gallbladder, in my experience, is not usually seen unless it is distended. The spleen is seen only if enlarged. The uterus, tubes, and ovaries may sometimes be seen if elevated by vaginal manipulation. It is never possible to see the posterior wall of the stomach, duodenum, common bile duct, pancreas, adrenals, kidneys, mesentery, or great vessels.

Indications for peritoneoscopy

In any abdominal or pelvic condition where the diagnosis is obscure or where additional evidence is necessary to confirm the diagnosis, peritoneoscopy is indicated.

1. Ascites of undetermined origin. Removal of ascites allows for greater distention with air and a better view of abdominal contents than can be obtained where ascites is not present. Cirrhosis of the liver, carcinomatosis of the peritoneum, ovarian malignancy, or tuberculous peritonitis are easily distinguishable.

2. Liver enlargement from hepatitis, cirrhosis, or carcinoma.

3. Carcinoma of the stomach (for resectability) after diagnosis is made by x-ray or gastroscopy. Fifteen to twenty per cent of carcinomas of the stomach have liver metastases when first discovered. This fact can be determined by peritoneoscopy in almost 100 per cent of cases, as can peritoneal implants. Many surgeons believe that peritoneoscopy should be done on every case before laparotomy. The presence of extension of the gastric lesion posteriorly can not be determined this way, however, so that even with a negative peritoneoscopy the lesion may be found to be inoperable.

4. Ectopic pregnancy can be diagnosed and, if this is found, laparotomy can follow immediately. If a normal pregnancy is found, the procedure is not traumatic enough to produce an abortion.

5. Stab or bullet wounds of the abdomen to determine whether the peritoneum has been penetrated. By introducing the scope through another site and inserting a probe through the site of the wound, penetration or lack of it is easily ascertained.

Contraindications

1. Possible presence of bacterial infection in the peritoneal cavity.

2. Any acute abdominal condition, except ectopic pregnancy.

3. Presence of pleural fluid, as pneumoperitoneum decreases vital capacity. Thoracentesis should be done first.

4. Cardiac decompensation.

Limitations

1. Extensive adhesions which interfere with visualization.

2. Extreme adiposity because of thick abdominal wall and fatty omentum.

Dangers of the procedure are few and consist mainly of the possibility of puncturing viscera and of air embolism. Unless there are many adhesions, the danger of puncturing a viscus is slight; if the adhesions are dense enough to cause this, the bowel is usually sufficiently adherent to the abdominal wall so that soiling by the abdominal contents does not take place.

With liver biopsy there is also the danger of hemorrhage. The prothrombin content should be checked before liver biopsy is done and it is our practice not to take a biopsy if the prothrombin is below 50 per cent. Cautery may be used but is usually unnecessary. Fibrin foam is also available. After the procedure it is well to have the blood pressure checked hourly for four to six hours.

We have used peritoneoscopy quite extensively in our studies on the treatment of cirrhosis of the liver for the past three years. Liver biopsies have been taken on all patients before beginning treatment and again after treatment has been carried out for a month or six weeks. We have used a Vim Silverman needle in preference to the biopsy forceps because a sample of tissue is obtained from a greater distance beneath the liver capsule. This we think gives a more representative sample of liver tissue. Also we have found that with the fibrosis present in cirrhotic livers the tissue is too hard for the biopsy forceps to penetrate satisfactorily. In the cases with small livers, peritoneoscopy is done for each biopsy. The needle is introduced through a separate site and visualized as it goes into the liver thus eliminating the risk of puncturing adjacent viscera.

Summary

Peritoneoscopy is a valuable procedure to increase accuracy of diagnosis of abdominal pathology. It is indicated in differential diagnosis of ascites or enlarged liver; to determine presence or absence of metastases in carcinoma of the stomach before laparotomy; in ectopic pregnancy; or in stab wounds of the abdomen to determine degree of penetration. A description of the instrument and procedure is included.

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INTERNATIONAL CONGRESS ON OBSTETRICS AND GYNECOLOGY

The Board of Directors of the American Committee on Maternal Welfare have agreed to sponsor an International Congress on Obstetrics and Gynecology. The Conference will be held in conjunction with the Fourth American Congress at the Hotel Pennsylvania, New York, May 14 to 19, 1950.

Preliminary plans include a program in which each morning of the four-day scientific sessions is to be devoted to formal presentation and discussion of a general topic. The afternoon sessions are to be given over to round table and informal discussions of these subjects. Tentatively selected are cancer of the female genitals, physiology and pathology of reproduction and gynecologic procedures.

The field of obstetrics and gynecology involves wide implications, therefore it is important to include all interested groups—doctors, nurses, hospital administrators, public health personnel, and medical educators. An additional session at the close of the conference may be devoted to a presentation of economic and sociologic problems under the auspices of the National Federation of Obstetric-Gynecologic Societies.

In addition to the academic presentations to be made at the Congress there will be extensive technical and scientific exhibits, as well as social events. It is likewise planned to develop clinics in various of the larger medical centers and hospitals of the country both before and afterwards, so that foreign visitors will have an opportunity to acquaint themselves with the advances of American institutions in this field.

The executive offices of the Congress are located at 24 West Ohio Street, Chicago 10, Illinois, U. S. A., and all inquiries should be addressed to the General Chairman, Dr. Fred L. Adair.

Recent Advances in the Field of Otolaryngology

Ella M. A. Enlows, Ph.D., M.D.

Antibiotics and Chemotherapeutic Agents: Many of the acute infectious diseases of the nose, throat, and ear can be treated successfully by means of the antibiotics (penicillin, streptomycin) and the chemotherapeutic agents (sulfadiazine, sulfathiozole, sulfanilamide) without the aid of surgery. However, early diagnosis and adequate early treatment are essential, whether they are used alone or are combined. In the chronic infections, surgical removal of the infectious foci is usually indicated along with the antibacterial treatment. Intramuscular injections of the antibiotics give the best results. Where this is impossible, fair response is obtained from the oral route. Sensitivity to these antibacterial agents must be guarded against, even though it is less frequent now with the more perfected products.

Nebulized penicillin solutions were introduced by Bryson,[1] and by Barach and associates[2,3] a few years ago, and suitable apparatus devised for their use in the treatment of upper respiratory infections. Recent results have been reviewed by Segal.[4] Three to four daily treatments should be given over a period of 3 days to 2 weeks, depending upon the acuteness or chronicity. But little benefit is obtained when there is allergic involvement or in the presence of obstructed drainage.

The literature as to the local use of the antibiotics in the treatment of acute and chronic sinusitis is plentiful. Varying results are reported, which remind us of the overenthusiasm, and frequently the subsequent disillusionment, following the use of the sulfonamides used locally for this purpose. Used in this way the sulfonamides are germicidal and the antibiotics are bacteriostatic; but little regard has been given to the concomitant injury of the first line of defense—the mucous membrane. Nasal medicaments should be compatible with ciliary motility, as Proetz and many others have demonstrated. With this in mind we cannot disregard the hydrogen ion concentration and the other traumatic possibilities of the solutions used. Proetz's displacement may be employed for the local treatment of the paranasal sinuses, or the modification reported by Hymes,[5] which may be used by the patient in his home. Fabricant and his associates[6] conclude that sodium and calcium penicillin solutions containing one to five thousand units of penicillin per cc. (pH 6.5) may be applied topically to the nasal mucous membrane without ciliary damage or other toxic effects.

The use of penicillin solutions in the external auditory canal for the treatment of acute and chronic otitis media has given varying results. There is general agreement that improvement may be expected when this method is used with intramuscular injections. If the topical instillation of penicillin solution is alternated with sulfadiazine (in ethanolamine solution) daily, better results follow. Rawlins[7] reports success in the treatment of chronic aural discharge (non-operative) by the use of 1000 units of penicillin per cc. in a solution of equal parts of 70 per cent alcohol and saturated glycerin (35 per cent alcohol and 50 per cent glycerin). This solution is instilled twice daily, for two weeks, with the head resting on the good side for twenty minutes.

Ballenger,[8] using a standard powder blower motivated by compressed air, insufflated powered sulfonamide compounds, alone or in various combinations, into the noses and throats of over 1500 persons during a three year period. He found them non-irritating to the mucous membrane, nor was there any evidence of slowing of ciliary activity. They were non-inhibiting on the viruses of the common cold, but were definitely inhibiting against the secondary invaders—streptococci, pneumococcus, and Staphylococcus aureus. The sore

throat and inflammation of the palate, nasopharynx, and pharynx were frequently stopped within twenty-four hours. The greatest usefulness of the procedure was in the early stage of infection.

Goldman and Kiesewetter[9] using the insufflation technique (sulfanilamide) in military personnel with acute pharyngitis and tonsillitis report that the average length of time spent in the hospital was lessened by approximately one-fourth. The patients were treated twice daily. No sensitivity was observed.

Allergy: Much has been written on the use of the new antihistaminic drugs in treating the various manifestations of allergy. Certain antibodies known as "reagins" are formed when an antigen to which a patient is sensitive enters his system. The action of antigen and reagin together in the tissues or blood stream releases histamine or a histamine-like substance which brings about various manifestations, such as urticaria, allergic rhinitis, asthma, etc. These newer drugs are used in an effort to counteract the effect of the histamine. Benadryl and pyribenzamine have been most widely used. They are most effective when used along with attempts at control of the offending antigen, either by desensitization or avoidance. Side effects (vertigo, drowsiness) seem more common with benadryl than with pyribenzamine. Occasionally allergic reactions occur due to these drugs themselves. Agreement is rather general that they are palliative, not curative. In some patients they are almost dramatically effective in the treatment of allergic rhinitis and urticaria, least effective in asthmatic cases. Levin[10] reports that 60 per cent of 223 patients with various allergic symptoms were relieved with benadryl. Improvement resulted in 57 of 87 asthmatic patients. It was, however, almost without effect when the asthma was precipitated or accompanied by respiratory infection. Goodhill[11] studied the effect of the oral administration of pyribenzamine to 120 patients with acute or chronic allergic rhinitis. For the relief of sneezing and itching the drug was 90 per cent effective; for relieving the rhinorrhea and nasal congestion, only about 70 per cent effective. He also observed diminished skin reactivity to pollen extracts in patients previously sensitive. A good summary of the newer antihistaminic drugs is given by Waldbott[12] who concludes that undoubtedly the greatest significance in their development is the new principle which has instigated their trial.

Ménière's Syndrome (Endolymphatic Hydrops): Many authors regard this disabling disease (vertigo, tinnitus, and deafness) as an allergic manifestation. Williams[13] believes that a combination of antihistaminic medication and control of water and sodium intake offers the best results. When all types of medical treatment fail he prefers Day's technique of fenestration and destruction of the labyrinth to Dandy's intracranial division of the eighth nerve. On the other hand, Crowe[14] believes that the intracranial division of the vestibular nerve is a safe and simple operation in the hands of an expert neurosurgeon.

The Dental Bite and Auditory Disturbances: It has been found by many otologists during the past ten or more years that a number of cases of deafness, tinnitus, vertigo, face and head pain, can be helped and at times cured by adjustment of abnormal dental bites. This important subject is reviewed adequately with good illustrations by Goodfriend.[15] The greatest difficulty is securing the co-operation of the patient's dentist. Few dentists appreciate the importance of the temporomandibular joint to the function of hearing.

Deafness and Nasal Dysfunction of Psychogenic Origin: We have had the "psychogenic nose" with us for many years, but only recently have we realized the psychogenic origin of some of the lesser degrees of deafness. Complete deafness of this type has of course been well recognized. Truex[16] studied 4000 soldiers who had been under severe stress. Twenty per cent of the patients admitted to the Aural Rehabilitation Service were referred to the psychiatrist, and 90 per cent of these were found to have definite psychiatric abnormality. About 30 per cent showed some functional hearing loss. He found the Doerfler-Stewart[17] test of exceptional value in differentiating organic from psychogenic hearing loss.

Nasal dysfunction associated with emotional states has been well presented by Holmes and his associates,[18] who recognized two patterns: (1) Vasoconstriction, with resulting increased air space. Such changes accompanied feelings of fear, sadness, and other emotions which, although strong, involved minimal conflict. (2) Initial hyperemia, associated with turgescence of the erectile tissues in the turbinates and septum, engorgement of the mucosa, and increased secretion. Secondary pallor may follow, thus resembling vasomotor rhinitis. Fowler[19] in discussing the paper of Holmes, emphasized the difficulty of therapy and the lack of much help by the psychiatrist. He believes that narcosynthesis is rarely the answer in civilian life.

Radium Treatment of the Nasopharynx: The establishment by Crowe of a radium clinic in the otolaryngologic dispensary of the Johns Hopkins Hospital several years ago marked the beginning of a new era in the work of deafness prevention and cure. Crowe[20] concludes that irradiation with the nasopharyngeal radon or radium applicator may be used on patients of all ages to remove lymphoid tissue in locations inaccessible to ordinary surgical measures. He states further that it is "effective, safe, painless, and inexpensive and has proved particularly valuable for prevention and treatment of certain ear, sinus, and bronchial conditions in children."

Prevention of Acoustic Trauma: Rüedi and Furrer[21] point out that if frequencies ranging from 2000 cycles per second upward can be damped conversational speech may be retained. These authors have described an ear protector which will provide the needed damping for the desired frequencies. An outer shell covers the entire ear; small openings stud this shell, which acts as a resonator with its resonating frequencies very much damped. Complete protection is obtained by its use from all sorts of acoustic trauma. There is practically no hearing impairment.

Auditory Impairment of Airline Pilots: Graebner[22] obtained routine audiographs of 449 airline pilots and found a gradual deterioration of hearing with progressing years. He concluded that there is a causal relation between auditory decline and professional aviation.

Developments in Surgical Procedures: The fenestration operation for the improvement of otosclerotic deafness was brought to a one-stage technique and endaural approach by Lempert in 1938.[23] The operation is designed to replace the non-functioning oval window by an opening in the bony capsule of the external semi-circular canal; and to provide some method of maintaining the patency of this new window or fenestra. The results are good in properly selected patients so long as the fenestra remains open, but closure has been frequent.

In 1941 Lempert[24] decided to place the window in the ampullated end of the external semicircular canal where the circumference of the perilymphatic space is greater and thus closer to Shrapnell's membrane, and where it could more easily be covered by this membrane. Shambaugh,[25] modified the Lempert technique by using continual irrigation and the microscope. This procedure tends to avoid the stimulating effect on osteogenesis of bony particles and bone dust created by the burr. Later Shambaugh[26] also advised enchondralization of the fistula, and the placing of the fistula in the extreme lateral or even the inferolateral surface of the canal in order to increase mobility between the tympanic membrane and the fistula. He also used sterilized sea-sponge packing against the skin flap covering the fenestra, and a head frame to maintain the cochlea in a position superior to the fenestra. Recently Lempert[27] has advised the use of a lead burnishing burr in order to devitalize and inactivate the histologic layers of the bony rim of the fenestra. He expresses the hope that this newer technique may improve the results obtained previously. About 80 per cent of his operations have resulted in improved hearing lasting for varying periods. Only about 75 per cent of the "improved" cases maintained the "practical and serviceable unaided hearing for more than two years and permanently thereafter."

The Ballance and Duel Operation for Bell's Palsy: Many patients suffering from peripheral disease of the facial nerve have been cured or helped by this operation. It is a decompression of the facial nerve from the stylomastoid foramen to the external semicircular canal. Recently Kettel[28] has presented a complete study of his results with this operation. He concludes that it is indicated (1) when signs of beginning mobility have not appeared after two months; (2) if the spontaneous recovery of mobility has been only partial; and (3) in cases of relapsing paresis. He believes that the improvement on exposure of the nerve may be due to improved circulation of the blood.

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VETERANS ADMINISTRATION

More than 50 types of sports—some adapted to the physical limitations of the ill and disabled—are available to patients in Veterans Administration hospitals who obtain permission from their physicians to participate.

* * *

Veterans Administration predicts that in the year 2000, more than 3,400,000 World War II veterans will be alive. Their average age will be nearly 78.

Of the 18,624,000 veterans of all wars on January 1, about 14,745,000 served in World War II. The remainder were in World War I, the Spanish-American War, Civil War and Indian Wars.

* * *

Veterans Administration supplied disabled veterans with nearly 300,000 prosthetic appliances (excluding batteries for hearing aids) during the fiscal year ending June 30, 1947. The total includes 157,500 stump socks for amputees, 32,000 pairs of eye glasses for veterans with exceptionally poor vision, 17,000 pairs of arch supports, 16,000 braces, 9,400 hearing devices and 8,000 artificial legs.

* * *

During the fiscal year ending June 30, 1947, a total of 27 accredited schools of social work placed 105 students in Veterans Administration hospitals for graduate field training.

Medical records of more than 100,000 ill and disabled World War II veterans will be used to aid researchers in their efforts to discover the causes and cures of little-known diseases and unusual injuries.

Object of the program is to analyze the medical records of such veterans, and through study of the history of their ailments and of the medical treatment given, thus attempt to arrive at sound medical conclusions and recommendations for the care of others who might incur these same disabilities.

The research extends beyond the time veterans are in hospitals to determine causes of relapses and other after-effects suffered in many cases after medical treatment has been given; the work will cover a wide variety of diseases and injuries.

VA, individually, or in collaboration with the Research Council, and the Departments of the Army, Navy and Air Force, will determine the specific studies to be conducted.

Contents of all medical records used will be carefully guarded. Before being designated to participate in these clinical studies, physicians other than VA employees, will be required to sign statements pledging they will safeguard the confidential contents of the records reviewed.

While advantages accruing to science and practice will be shared by the medical profession as a whole, VA will be the primary beneficiary of the program.

Some studies will be conducted in VA hospitals by VA physicians or by accredited representatives of the National Research Council. Others will be carried on in the medical schools of outstanding universities.

Early Medical Service of Women

Frederick C. Waite, Ph.D.

THE ADMISSION of Elizabeth Blackwell to Geneva Medical College in October 1847, and her graduation with the degree of Doctor of Medicine in January 1849, was not the establishment of a policy, but only an episode. That institution graduated only one other woman during its existence and that one sixteen years later. This incident is commonly taken as the beginning of the history of medical service of women in the United States, but ignores the extensive medical service of women from early colonial days, not only as midwives, but in administration of medicaments, especially in rural communities.

The opposition of male physicians to the practice of medicine by women was not an isolated attitude confined to the medical profession. Such opposition was equally prevalent regarding the practice of law by women or their entrance to church pulpits. The men firmly believed that the entrance of women to any profession would degrade the sex.

Institutional instruction of women for medical service began in Boston, where a physician induced a group of women to establish in that city in 1848 an institution for thoroughly training women in obstetrics. The field of teaching was soon widened and a charter obtained permitting the granting of the degree of Doctor of Medicine. The first four women were graduated in 1854. Thus arose the New England Female Medical College which continued until 1874 when it was merged with a recently established medical college for men to become the present Medical Department of Boston University.

Dr. Waite, now emeritus professor at Western Reserve University, was head of the Department of Histology and Embryology in the Medical School from 1901 to 1940. He has published many papers on dental and medical education as well as biographical articles on Medical Women of the Nineteenth Century.

Lydia Folger Fowler, M.D., the second woman to receive a medical degree in the United States.

The fragmentation of the Thomsonian sect in the early eighteen-forties gave rise to several new medical sects. One of these was the Eclectics, who established their first medical college in Cincinnati in 1845, and soon founded a medical college at Rochester, New York, where Lydia Folger Fowler was graduated in 1850, the second woman to receive a medical degree in the United States. The Eclectics strove to increase the number of their adherents, and sensing some support for the medical education of women, the National Eclectic Medical Association in 1852 advocated admission of women to medical colleges that were primarily for men, the first declaration of a policy of co-education in medicine.

The medical colleges for women at Boston and Philadelphia were already in operation and had established a policy of separate medical education for women. However, when these two institutions were founded there were no medically educated women to form their faculties and regular physicians declined to accept professorships. Therefore, both institutions appointed sectarian practitioners as professors, with the result that both of these institutions were considered irregular.

Thus, by 1853, the institutional medical education of women was imbedded in Eclecticism, which was anathema to regular practitioners. The medical college for women in Philadelphia attained regular standing after a few years.

Practically all writers on the entrance of women to the medical profession in the United States restrict their discussions to the refusal of medical colleges to enroll women. This was not the primary nor the major difficulty. One might enter legal medical practice without attendance at a medical college and more than one-half of the medical practitioners of the first half of the nineteenth century never enrolled in a medical college. The primary difficulty for a woman desiring to enter the medical profession was to find a licensed physician who approved of medical education for women and would accept her as a private student and become her preceptor.

The fact that the sectarian medical colleges were lax in enforcing three years of medical study under a licensed physician before graduation was a factor in the entrance of women to sectarian colleges. Many of these institutions accepted desultory reading of medical books without supervision as constituting the three years of medical study required for the medical degree. The Eclectics, and less extensively the Homeopaths, exploited women as medical students in order to augment the number of adherents to their sects.

The Medical Service of Women in the Western Reserve

Charles II granted a charter to the Colony of Connecticut in 1662 with definite north and south boundaries, which extended westward to the Pacific Ocean. Parts of the area were lost by subsequent royal charters to New York and Pennsylvania. That part west of the Mississippi River was lost to France. However, at the close of the Revolutionary War the State of Connecticut had undisputed title to an area approximately sixty miles from north to south and extending from the western boundary of Pennsylvania about four hundred miles to the Mississippi River, when the federal government asked all States to release their "western claims" to meet the public debt.

A compromise was reached under which Connecticut released the western part of her "western claims but "reserved" an area equal to the original length of the State. This area lay between the same parallels of latitude as Connecticut and extended westward one hundred and twenty miles from the western boundary of Pennsylvania. This was "Connecticut's Western Reserve." Colonization was begun in 1796. Inasmuch as there was no other similar reserve it soon came to be called "The Western Reserve." The area was what is now northeastern Ohio.

Western Reserve College, the first college in the Western Reserve, was founded at Hudson, Ohio, twenty-six miles south of Cleveland, in 1826. Its charter was broad enough to include professional departments. Several efforts to organize a medical department of Western Reserve College finally resulted in the founding, under its auspices, of a medical college in Cleveland in 1843. This was a regular medical college with no mention of the admission of women.

Nancy Talbot Clark, M.D., Medical Department of Western Reserve College, 1852. The first woman to be graduated in medicine west of the Allegheny mountains.

A few women were graduated in the eighteen-fifties. The first woman to be graduated in medicine west of the Allegheny Mountains was Mrs. Nancy Elizabeth Talbot Clark, of Massachusetts, who received her degree from the Medical Department of Western Reserve College on March 2, 1852. After three years of practice in Boston she went to Europe for further study but on her return married a prominent Boston physician and gave up private practice. However, she established a free gynecological dispensary in Boston which she personally attended daily during many years. She died in 1901 at the age of 76 years.

Emily Blackwell, the younger sister of Dr. Elizabeth Blackwell, applied for entrance at Geneva Medical College in 1852, but was refused admission. She was accepted at Rush Medical

MARIE E. ZAKRZEWSKA, M.D.
(From a photograph thought to have been taken some time in the '60's.)

Two of the four women to receive the M.D. degree from the Medical Department of Western Reserve College in 1856.

College, but at the end of one session was denied further enrollment upon the advice of medical societies. She was admitted to the medical college in Cleveland, and was graduated in March 1854. She spent some time in further study in Paris, London, and Edinburgh, and then joined her sister in practice in New York. The careers of the two Doctors Blackwell included establishment of a dispensary, a hospital, and a medical college for women. Dr. Elizabeth Blackwell is more widely known, because of priority in graduation, but the younger sister was better educated, did most of the administrative work in the New York institutions, and was the first woman physician to engage extensively in major surgery. She died in 1910 at the age of 84 years.

The admission of Nancy Clark and Emily Blackwell at Cleveland brought applications from other women, resulting in the graduation of four women at Cleveland in 1856. They were Sarah Ann Chadwick of Illinois, Cordelia Green of upstate New York, Elizabeth Grisselle of Ohio, and Marie Elizabeth Zakrzewska of New York. Dr. Chadwick practiced nearly fifty years in Illinois. Dr. Grisselle practiced in Ohio more than fifty years. Dr. Green, whose father was a physician, conducted a sanitarium in New York State during many years. She gave especial attention to mental diseases and for several years was a consultant for women inmates in all the insane asylums of New York State. She also was the author of several books.

The most colorful of the four women graduated in 1856 was Marie Elizabeth Zakrzewska. Born in Poland, she was graduated in Berlin from a school for midwives of which she became accoucheuse-in-chief, and was, for a time, assistant of Johannes Müller, famous physician, teacher, and scientist of Berlin. She came to New York in 1852 and joined Dr. Elizabeth Blackwell in dispensary work until she became familiar with the English language. Dr. Blackwell secured entrance for her at Cleveland, where Dr. John Delameter was her preceptor. After graduation she returned to New York and assisted the Doctors Blackwell in the establishment in 1857 of a hospital for women and children. In 1859 she went to Boston as Professor of Obstetrics and Diseases of Women in the New England Female Medical College. After two years she resigned to establish the New England Hospital for Women and Children in 1861, the first hospital of this type in New England, and still in operation. In 1872 in this hospital she established the first training school for nurses in the United States. She died in 1902 at the age of 76 years. The average age at death of the six women graduated at Cleveland in the eighteen fifties was 78 years. Five of them practiced approximately fifty years each.

Each of the eight women admitted to the Cleveland school in the eighteen-fifties was accepted through the personal influence of Dr. John

Delamater, beloved dean of the medical college, to whom the medical women of the United States owe a debt of gratitude for introducing co-education in regular medical colleges. He was the leading obstetrician of northern Ohio, and, while men students were not admitted to obstetrical deliveries, these women were readily admitted and received extensive practical instruction in obstetrics. After his health deteriorated in 1856, changes in the faculty brought a decision to admit no more women students. Local medical societies influenced the Cleveland policy. They opposed medical education for women because the women had become essentially an element of irregular medicine. This group of six women was the largest group of women graduates in any regular medical college before 1870.

Homeopathic Medical Education of Women in Cleveland

No medical college of the Eclectic sect existed in Cleveland at any time. The Western College of Homeopathic Medicine in Cleveland began instruction in 1850. It graduated the second woman in medicine west of the Allegheny Mountains six days after the graduation of Dr. Nancy Clark in 1852. The policy of admission of women blew hot and cold in this institution. Frequent changes in the faculty brought men of differing opinions, and in 1867 the decision was reached to admit no more women as candidates for the degree of Doctor of Medicine and women applicants were advised to attend a homeopathic medical college for women recently founded in the City of New York.

Thereupon, the Homeopathic Hospital Medical College for Women was founded in Cleveland. It existed four years and graduated seventeen women and then was merged into the parent institution. Women were admitted continuously to the several homeopathic institutions in Cleveland from 1871 until the last one closed in 1914.

Medical Education of Women in other Regular Medical Colleges of Cleveland

The extrication of the medical education of women from involvement in sectarianism began in 1865 when the Medical Department of the University of Michigan adopted a policy of co-education which was thus made respectable in regular medical colleges.

A regular medical college established in Cleveland in 1864, under another name, became the Medical Department of Wooster University in 1870. Following the example of the University of Michigan and because the parent under-graduate college was co-educational, women were admitted, and the first woman was graduated in 1872.

The Medical Department of Ohio Wesleyan University (whose precursor was the Medical Department of Wooster University) and the Medical Department of Western Reserve College were combined in 1881 under the name of Medical Department of Western Reserve University and admitted women, of whom three were graduated, the last one in 1884.

The number of women graduated in medicine in Cleveland from 1852 to 1914 was as follows: Medical Department of Western Reserve College and University, 9; Medical Department of Wooster and Ohio Wesleyan Universities, 62; Homeopathic institutions under various names, 260. It is seen, then, that approximately 80 per cent of the women graduates in these years were from sectarian institutions. The sectarian influence was similarly preponderant in other parts of the United States.

Herein lies the major cause of opposition to women physicians, which had its basis far less in sex than in the fact that the great majority of women physicians of the nineteenth century were the product of sectarian institutions. They were decried, not only because of therapeutic vagaries, but also because the level of educational standards in the sectarian medical colleges was far below the average in regular medical colleges. The Homeopathic medical colleges were less numerous and of a little better average quality than the eclectic institutions, but any reference to a woman physician in the nineteenth century implied that she was probably an adherent of one of the sects and therefore poorly educated. Some individuals improved their status by subsequent study.

Summary

The conditions of the early medical education of women constituted a vicious circle. Regular physicians originally opposed the entrance of women to medicine from a spirit of gallantry. Then the sectarians exploited the women and regular physicians decried women physicians as a group because the great majority of them were sectarians. The cause of a gradual change in this attitude was the deterioration of the sectarian

medical colleges, and finally their almost total elimination in the advance of standards of medical education beginning about 1885, which sectarian institutions could not meet.

The result was that by about 1900 the number of women graduating from regular medical colleges was equal to the products of the sectarian institutions and soon in excess. The passage of time has removed nearly all sectarian women graduates from active practice.

In Cleveland during the first world war the opinion arose that a long war would call so many male physicians to the colors that medical service to civilians would be deficient. Thereupon, the authorities of Western Reserve University decided, in 1918, to admit women to the medical school. The first were admitted in 1919 and graduated in 1923. Seventy-nine women have been graduated from 1923 to 1947 inclusive.

The Woman's Hospital of Cleveland

Frances E. Pickett, M.D.

Chairman of The Board of Woman's Hospital

In the year 1878, several homeopathic physicians, under the leadership of Dr. Myra K. Merrick, organized the Women's and Children's Free Medical and Surgical Dispensary. The purpose of this organization was, according to an annual report published in 1897, "to furnish clinical advantages for young women physicians and students as well as a place where self-respecting women of limited means could receive for a moderate amount, or free if necessary, the services of physicians of their own sex." The report stated further that male students were barred, as the initial principle of the institution had been that poor women should be spared exposure, if possible, and treated as delicately as their more fortunate sisters. That a large number of shrinking sensitive women, impoverished by the countless changes of fortune for whom public clinics would be worse than death."

These pioneer women physicians used social service workers in their clinic and stated that "it has been demonstrated that social assistants are of great value in connection with medical work."

Through the generosity of John D. Rockefeller, Sr., a former Clevelander, one bed at the cost of $250.00 per year was maintained at Huron Road Hospital for patients needing hospitalization. The name of Mrs. Rockfeller appears in several yearly reports as a contributor of amounts varying from $25.00 to $250.00, another contributor of the struggling Dispensary was Mrs. H. M. Flagler, whose husband was associated with the development of Miami, Florida.

Dr. Myra King Merrick, one of the Founders of the Woman's Hospital of Cleveland.

In 1894, the Dispensary was incorporated. Since its organization sixteen years previously it had been necessary to move three times and its founders were looking about for a permanent home. The hard times experienced in the early nineties were keenly felt. Necessary carfare to reach the Dispensary was not always available; yet there was an average yearly attendance of over six thousand patients.

With the financial aid of many small donations a house was purchased on Webster Street. It was conveniently located in a district from which many of the patients came. However, the pressing need of a hospital where women physicians could take their patients and care for them was recognized by these intrepid women and their far-sighted manner of handling the problem is set forth in their annual report of 1912. It is as follows: "We have for a long time been impressed with the great need of hospital facilities. At present if a patient requires hospital care our resident physician must give up attending the case, as only patients having private room rates can employ their own physician.

"Again, without hospital facilities neither our resident nor staff physicians have the opportunity to perfect themselves in certain specialties, notably surgery, as very few hospitals have women resident physicians and no general public hospitals have women on their staffs and all charity patients are treated by the staff.

"Because we felt the necessity of changing our location and enlarging the group of our work, our president called us together a year ago to discuss plans for the future. We decided that the time was at hand for us to take this step forward and that the hospital project which we contemplated ought to extend its privileges to all schools of medicine; consequently our invitation was extended to the women physicians of the regular school of medicine to meet with us and consider a Federation. The meeting was held at the Y.W.C.A. Building on February 16 (1912). The outcome of this meeting was the appointment of a committee to consider the matter and report on the advisability of such a movement. This committee reported March 8, that the following resolution had been unanimously adopted: Resolved that the women physicians of Cleveland take over the Women's and Children's Free Medical and Surgical Dispensary and reorganize with the view of establishing a Woman's and Children's Hospital, Maternity, and Dispensary. There were nineteen physicians present when the question was put, and it was unanimously adopted. The next step was the drawing up of a constitution, and the election of officers, Dispensary Staff, Fiscal Trustees, and a Managing Board of Women.

"It was voted to prepare a constitution which would permit the undertaking of the hospital project at any time, to secure a charter permitting us to change our name to The Woman's Hospital Association of Cleveland, stating an enlargement of our object as follows: (a) To establish a Hospital and Dispensary for women and children; (b) To conduct a training school for nurses; (c) To inaugurate a social service system; and further to reorganize the Dispensary Staff and give our immediate attention to changing our location and developing our Dispensary work in that locality.

"The constitution of The Woman's Hospital Association was adopted September 12 (1912). Two weeks later officers of the Association were elected and since then a Fiscal Board of Trustees and a Board of Managers have been elected and a Dispensary Staff appointed."

A house on Cedar Avenue was leased and The Woman's Hospital opened with a capacity of twelve beds; however, the hospital remained there only a year or two, after discovering that one of their immediate neighbors was in the tar business and kept numerous tar barrels in close proximity to the newly established hospital, constituting a very real fire hazard.

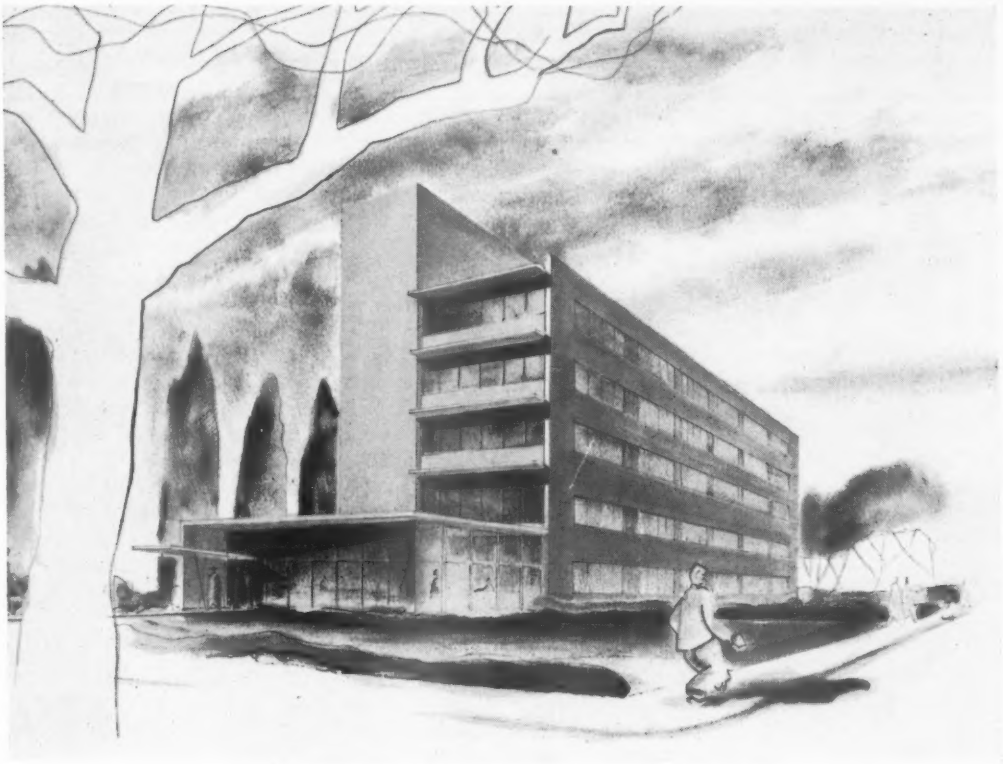
The next move was to a brick house on East 107th Street, where twenty patients could be housed. The hospital remained there until 1918, when the Hospital Association purchased our present building on East 101st Street, near Euclid Avenue.

This structure was formed by joining two apartments and adding a wing in the rear. It had formerly been used as a sanatorium. Thirty years ago, when we took possession, the building was old and with the housing of laboratories and the x-ray department, and the ever expanding service facilities of a modern hospital our once "commodious" quarters are entirely inadequate for the work we are now doing.

In the past ten years we have acquired several small properties adjoining our present site and plans for erection of a new modern hospital are nearing completion. It will give us a capacity of 125 beds with the building so planned that it can be expanded to 165 beds in the future.

The status of women physicians here or elsewhere has changed and staff opportunities are now available in practically all hospitals.

As we all know, two World Wars in the past twenty-five years have, because of the great need of physicians, given women opportunities to demonstrate their abilities. While our Staff is composed of both women and men, our Hospital does offer, in full, equal opportunities in that a woman



Architect's drawing of the new Cleveland Woman's Hospital.

physician may head a department if she is properly qualified. Furthermore, the hospital is owned by The Woman's Hospital Association and its policies are controlled by women physicians.

With humility and gratitude we look forward to the realization of the long cherished dream of several generations of women physicians of Cleveland and upon completion of our new Woman's Hospital we shall dedicate it to the memory of those valiant women who comprehended so clearly their obligations to society and to their chosen profession.

RURAL CHILD HEALTH

At the third annual National Conference on Rural Health held in Chicago, February 6 and 7, the health problems of the rural child received special attention. Dr. Lee Forrest Hill, past president of the American Academy of Pediatrics offered the following 8-point program:

"If the rural child is to have medical care commensurate with that enjoyed by urban children the first prerequisite should be an increased number of doctors in rural areas; second, an increased emphasis on pediatric teaching in medical schools; third, a longer period of internship for postgraduates, with from four to six months devoted to pediatrics; fourth, the establishment of rural hospitals as proposed under the Hill-Burton Bill with adequate technical personnel; fifth, rotation of pediatric residents from approved hospitals in pediatric centers through these rural hospitals for the benefit of both the residents and local doctors; sixth, frequent visits by consultants from the staff of the pediatric hospitals to the rural hospitals for ward rounds and teaching clinics; seventh, increased provision for post-graduate education of rural physicians in pediatrics both at the pediatric center and in the local communities; and, eighth, the establishment of premature stations wherever needed in each state."

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

VOLUME 3 MAY 1948 NUMBER 5

FOREWORD

THE EDITORS are happy to open the pages of the JOURNAL this month to contributions from the medical women of Cleveland, Ohio, who through the efforts of Dr. Marion N. Gibbons, Guest Editor for the month, are here presenting a series of outstanding articles. Our thanks go to each contributor and, in particular, to Dr. Gibbons for her help and for her interest in the Journal. Special mention should perhaps be made of Dr. Frederick C. Waite's interesting and illuminating paper on Early Medical Service of Women.

Since its first issue in April 1946, which was devoted to cancer, the JOURNAL has had several special issues. That for October 1946 was the Chicago Number, the material being collected by Dr. Beulah Cushman. November 1946, was an International Number, Dr. Esther P. Lovejoy having assembled reports of the meeting of the International Medical Women's Association held in London that summer. In March 1947, the New York Infirmary staff supplied the material, under the editorship of Dr. Ada Chree Reid. June 1947, was an Industrial Health Number, and July 1947 was devoted to reports of the Congress of the International Medical Women's Association in Amsterdam. For October 1947, a fine series of papers was supplied by the Woman's Medical College, Dr. Carmen C. Thomas acting as editor, and in December, Dr. Elizabeth Bass, Guest Editor, presented material representative of the best work of medical women of the South. April 1948, was again a cancer number.

The Editors call attention to this list not only as an expression of their appreciation of the interest shown by these groups, but also as evidence that there are still many centers of medical women not represented.

* * *

Dr. Marion N. Gibbons of Shaker Heights, Ohio, Guest Editor of this special Cleveland Number of the JOURNAL, *has limited her practice to internal medicine. She is a graduate of the Western Reserve University School of Medicine, in 1925, a diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians, and a life member of the American Medical Women's Association.*

THE OPEN MIND—THE OPEN HEART

THE LEVEL OF undergraduate medical education offered in this country within the past two decades is gratifying, and in the main very satisfactory. The accurate recognition of organic disease patterns by most physicians appears to be the rule, broadly speaking, but the appreciation of the emotional complications of the diseased state, and particularly the recognition of the so called "functional" or psychosomatic ailments have lagged far behind the organic diseases, not only in diagnosis but in treatment.

Myriads of articles on the subject of psychosomatic medicine have been crowding into medical publications during the 1940's. Not alone the general practitioner, but the surgeon, the orthopedist' the opthalmologist, and to a great degree the internist are lagging in offering to these suffering people the solace at least of a recognition of the source of many of the problems that completely incapacitate them or detract from their ability to live useful and happy lives.

During the war we were all burdened with a patient load that was too heavy for completely adequate individual medical care, but for that reason patients who are not medical or surgical emergencies now do not expect immediate office appointments. Most physicians can make time to talk to the new patients and can observe them with a seeing eye in a quiet first interview. In many cases assurance as to the organic or functional nature of the complaints, or the relative

proportions of each in the individual case, may be gained during the first careful examination. Conscientious physical examination must not of course be neglected though many functional elements are immediately obvious that should not be ignored or forgotten.

During examination there are many ways of reassuring the fearful, the depressed, and the insecure, if one's mind is open to the patient's fears and doubts. All of us have the experience of noting tenseness, increase in heart rate, and frank fear in the face of the patient who wishes help to cope with recurring cardiac arrhythmias, anginal syndrome, or hypertension. How simple it is for the physician to smile and make an encouraging remark, non-commital in nature, while examining the heart. Sometimes such a statement as "It seems to be minding its own business now," while listening to a heart that is prone to respond to anxiety with premature systoles will cause the patient to relax. With the hands acting as auricle and ventricle one can show the patient how the conduction from auricle to ventricle occurs, and that when the auricle "just can't wait" but gives a premature beat the ventricle does not respond, but waits, until the next auricular contraction, to contract vigorously so that the heart has seemed to the patient to stop and then to "turn over."

A careful explanation in a conversational voice and in simple terms of the difference between the voluntary and involuntary nervous systems and the action of the latter in fear or panic reactions on respiration, heart rate, and gastro-intestinal symptoms may bring immediate rapport between the frightened patient and the open-hearted doctor. Soon the patient may "open up" and talk about his problems without prodding.

Those of us with little psychiatric training must resist with all our strength the impulse to take the story out of the patient's mouth—to admonish, to advise, or to scold. Do resist that impulse! It may close the door to further opportunity to hear the patient's problems. Attempt to control the universal desire to wield power, to influence, and to direct the action of the one who seeks your help.

To a patient suffering from functional maladjustment the matter of fact acceptance of symptoms and problems as worthy of consideration, and bearing weight is a diagnostic and therapeutic interview will be great. Dr. William C. Menninger sums up the present reception given by the medical profession to "Individuals whose personality failure is expressed in somatic symptoms." He adds "Perhaps it is our system of medical education; perhaps it is our lack of orientation in psychiatry; whatever the cause, too many internists and surgeons are not stimulated to seek the cause or understanding of such human disease. In fact, their most common reaction is annoyance (unless the individual is a well paying client and then we are equally likely to be as unscientific). Rarely is this annoyance recognized for what it is, namely a defense for the physician's own ignorance."[1] Each of us who is honest will admit that he is right.

I believe it is important to use simple drugs at first to help control the annoying symptoms and to say frankly "This will help you now, you won't need it later." One may respond to the usual "Dr. So-and-So says it is all my nerves and I must learn to control them" by saying "Our emotions control our nerves and we have first to learn how best to deal with emotional problems, and that does not happen overnight." This will give the patient new hope and will save his damaged pride from further insult.

Often the family of the neurotic or psychoneurotic patient will have little sympathy for the multiplicity of troublesome symptoms he presents. An attempt to "save his face" when the patient must be talked over with relatives can be done because it is both the honest and the kindly thing to do. No suggestion is here made that formal psychiatric therapy be attempted by those of us whose training has not been adequate to prepare us for such service.

Seriously maladjusted individuals, including those with compulsive or obsessive symptoms, should be treated only by a competent psychiatrist, through whose skill, insight may be gained to recognize the causes of their major conflicts. As therapy, however, it will be essential that the therapist attempt to kindle a spark within the individual so that his sights may be raised above his own needs for personal gain, as revealed in his conflicts.

The ultimate aim of psychotherapy must always be to enable the patient to live in harmony with himself and with society. Such motivation can come only from within. In dealing with the less seriously handicapped neurotics such an attempt at teaching self-knowledge may be made by a trusted physician, and if in time a glimpse may be caught by the patient of the ultimate goal to be reached by the common effort for betterment of mankind the physician's efforts will not have been in vain. Not all neurotic patients can be referred for psychiatric help. The physician needs first to conquer himself, so that he refrain from

playing God, that he guide, not push, and aid in motivation but does not "take over" the troubled ones who need to be made finally aware that salvation lies within themselves.

Remembering too that patients with organic disease, acute or chronic, have fears as to their disease and may regress into dependency unless cheered and encouraged and permitted to talk of their fears will aid in convalescence and will help in the care of a patient with a chronic incurable disease.[3]

This used to be called "The Art of Medicine" and much has been written about it for centuries. How much we now have to offer the sick when modern diagnosis and treatment can be combined with the open mind and the open heart.

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Guest Editor

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ANNOUNCEMENTS

Industrial Health Courses at Columbia University

The revised and expanded teaching program in industrial health, inaugurated in the academic year 1947-1948 at the School of Public Health, Columbia University, will be continued during the school term which starts in September, 1948. Courses of study have been set up to train properly qualified physicians, nurses, engineers and chemists for specialized work in industrial medicine.

Physicians may be candidates for the Master of Public Health degree with major emphasis on industrial hygiene or may work for the degree of Master of Science in Industrial Hygiene. Graduate nurses who have a baccalaureate degree and are otherwise qualified may be accepted as candidates for the Master's degree in Industrial Hygiene. The normal course of study occupies an academic year of eight months, and students who have not had adequate practical experience may spend an additional period of from two to four months in field work.

The various curricula are designed to give the students a broad concept of the field of industrial medicine. The courses include general background in industrial medicine, occupational diseases and toxicology, industrial medical organization and administration, lectures, demonstrations and practice in engineering and laboratory methods as well as appropriate field work.

To round out the teaching program, courses are given in biostatistics, epidemiology, sanitation, public health practice, personnel management, public speaking, professional writing, health education and nutrition.

A feature of the work at Columbia is a weekly seminar in which physicians, nurses, engineers and chemists meet together.

In addition to the full-time curricula outlined above, opportunities are available to a limited number of part time students, not candidates for a degree, who may wish to enroll for individual courses each of which runs for a period of eight weeks, occupying from two to four hours a week. Physicians practicing industrial medicine in the metropolitan New York area should find this possibility particularly attractive.

Prospective students are invited to address inquiries to The Director, Columbia University School of Public Health, 600 West 168th Street, New York City 32.

International Conference on Poliomyelitis Announced

The National Foundation for Infantile Paralysis of the United States has announced that it will celebrate its tenth anniversary by sponsoring the First International Poliomyelitis Conference, to coordinate and evaluate the last decade of progress that medical science has made in the study of the disease. According to the announcement, it will be the first time that information on poliomyelitis, its treatment and research has been exchanged internationally on such an extensive basis. It is expected that the conference will bring together the world's outstanding laboratory and clinical authorities on poliomyelitis.

The meeting will be held July 12 to 17, at the Waldorf-Astoria Hotel in New York City.

Third World Congress on Mental Health

The Third World Congress on Mental Health will be held in London from August 11 to 21, 1948. It is expected to attract some 3,000 people from over fifty countries. The difficulties of reaching this country may be eased by the active support promised by UNESCO and WHO. The congress will embody international conferences on child psychiatry and medical psychotherapy (Aug. 12-15) and on mental hygiene (Aug. 16-21). The themes will be, in the first conference, foundations of mental health in childhood; in the second guilt; and in the third mental health and world citizenship. The congress committee headed by Dr. J. R. Rees, is exerting itself to ensure that the communications on this last topic shall represent all shades of opinion in each country. Sociologists, psychologists, educationists, and others are being invited to participate; and already discussion groups, or preparatory commissions, have been set up in this country and in North America to synthesize different individual views. The work of these commissions is coordinated from London by means of a monthly digest of activity in all countries. The organizers' hope is that international comparison will lead to a clearer understanding of the social relationships bearing on the well-being of the individual and of society. Information may be had from the congress office at 39, Queen Anne Street, London, W. 1.—The Lancet, Nov. 1, 1947, page 662.

Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

INTERNATIONAL SECTION

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UNITED NATIONS WORLD HEALTH ORGANIZATION

Interim Commission—Progress Report

WHO Aid in Cholera Research

A new filterable substance has been isolated from the culture of the cholera vibrio by Dr. E. Singer, WHO expert in bacteriology, it was announced this week at the New York Headquarters of WHO-IC. Dr. Singer is at present working with two Chinese doctors at the National Institute of Health in Nanking. This work has confirmed the existence of an antigenic substance which calls forth specific neutralizing antibodies in experimental animals and in humans vaccinated with cholera vaccine. Details describing this work have been submitted to the *Journal of Immunology* for publication.

Anti-Tuberculosis Program

A global anti-tuberculosis program, including intensified research and assistance to Governments in TB control, has been drawn up by the WHO-IC Expert Committee on Tuberculosis. The Committee concluded its four-day second session, during which the anti-TB drive was mapped, on 20 February in Geneva. According to current indications the program will probably be approved by the World Health Assembly when it convenes next June.

With TB assuming epidemic proportions in many countries as a result of the war, the problem of stamping out this disease has become particularly acute. Four to five million people, according to conservative estimates, die of TB each year. Ten times as many are infected. In order to eliminate tuberculosis the WHO-IC Expert Committee agreed that a systematic campaign should be waged along the following lines: (1) prevention, (2) case-finding, (3) isolation and medical care, (4) rehabilitation and after-care, and (5) social and economic protection to afflicted families.

The most pressing task is to apply preventive measures on as large a scale as possible. It was pointed out that "BCG vaccination" is at present the best practical method of inducing specific resistance to tuberculosis. Intensified use of BCG immunization was urged for countries where TB has become epidemic. At the Fifth Session of the WHO Interim Commission in January and February measures for active co-operation with the ICEF in its program to vaccinate 15,000,000 children and adolescents were discussed.

The greatest contribution which the WHO can make in the field of TB research, the Committee decided, would be by developing and recommending uniform procedures. Principal problems on which such action is needed are: (1) tuberculin and tuberculin testing, (2) preparation and clinical use of BCG, (3) classification of tuberculosis, (4) x-ray interpretation and mass radiology, (5) laboratory diagnosis of tubercle bacilli, and (6) evaluation of new chemotherapeutic agents such as streptomycin. In this connection, the Committee recommended that a streptomycin conference be called early in May in the United States.

The program also calls for fellowships and consultation services. It was recommended that

WHO should grant 50 fellowships to study new methods of combatting tuberculosis in accepted training centers in Scandinavia, France, the United Kingdom, and the United States. The establishment of training centers in Africa, India, China, and South America was urged for a later date. Expert advisers and demonstration teams would be made available to Governments, on request, as part of the consultation services.

The problem of tuberculosis among immigrants and tuberculosis in cattle likewise received the attention of the Committee. It urged that agreements be developed among Governments regarding medical examination, including chest x-ray, to detect tuberculosis among migrants in the country of departure. As bovine tuberculosis is spread not only by milk but also by direct contact with diseased cattle, nations whose herds have a high infection rate should take steps to eradicate cattle tuberculosis as quickly as possible.

"BCG Vaccine" is prominent on the agenda for the current meeting of the Expert Committee on Biological Standardization. A primary reason for this is the vast anti-tuberculosis drive about to be undertaken by the International Children's Emergency Fund, in co-operation with WHO-IC and other agencies. In order for this huge program, which will involve the vaccination of millions, to be assured of success certain standardized procedures will be essential. ICEF will be advised on the purely medical aspects of the program by WHO-IC. Meanwhile, preparation and testing of vaccines will be studied in detail at the Geneva meeting of the Expert Committee.

Summary of Medical Mission Operation.

China Mission

In China, beset by civil war and increasing economic difficulties, a WHO-IC medical mission has not only managed to carry forward emergency work taken over from UNRRA but is making substantial progress toward achieving its own 1948 objectives, according to Dr. C. K. Chu, Assistant Director of Field Services. Outlining the activities of the WHO-IC China Mission this week at his New York office, Dr. Chu stressed the fact that WHO in its field services does not contemplate future large-scale programs of actual aid in medical services, except in real emergencies. The chief function of the field services, he said, will be one of assistance and co-ordination in post-graduate training of indigenous senior public health and medical personnel. In addition, special emphasis will be placed on demonstrations in methods of combatting important communicable diseases, carried out by WHO representatives in co-operation with the national health services.

Such demonstrations have centered, as far as China is concerned, on the control of plague, cholera, TB, and kala-azar. They have been undertaken already at a number of places in China. Since WHO-IC began its work in China, in April 1947, demonstration centers on tuberculosis control work have been set up at Nanking, Shanghai, Peiping, and Tientsin. Demonstrations of plague control work have been carried out in Foochow and Nanchang. Other centers will be established during the current year, including several for the control of cholera and kala-azar. An expert on kala-azar was sent into the field last year, but military operations in the areas most affected by the disease prevented any attempt at demonstration of control methods.

Meanwhile, in the campaign against tuberculosis—a serious health menace in the cities of China, as shown by the surveys already conducted with the aid of the WHO experts—considerable local interest has been stimulated by demonstrations of mass x-ray service in the centers already established. In addition, a nation-wide anti-tuberculosis association has been founded just recently, and a New Year sales campaign of TB stamps undertaken. Plans for BCG vaccination have also been prepared and four specialists are being trained in the manufacture of the vaccine and in the conduct of vaccination campaigns. At present they are receiving instruction, under the WHO Fellowship Program, in the USA and Denmark.

During 1947, the training program for Chinese personnel in China could not be centralized and co-ordinated adequately, Dr. Chu explained, because of prior relief commitments made by UNRRA. However, the services of experts already at work in China for UNRRA were obtained by WHO for training purposes in Nanking, Canton, Mukden, Lanchow, Peiping, Shanghai, Kaifeng, and on the island of Formosa. Among these specialists are surgeons, sanitary engineers, gynecologist-obstetricians, ophthalmologists, and public health nurses.

The 1948 program of the WHO-IC China Mission envisages considerable intensification both in training activities for Chinese public health and medical personnel and in the development of further demonstration centers throughout the country. Assistance will be given to the Chinese Ministry of Health in carrying out its national post-graduate training program. In addition, a number of regional training centers will be given

assistance as needed, including such key cities as Peiping, Canton, Lanchow, and Shanghai. Dr. Chu pointed out that a major portion of the communicable diseases prevalent in China are filth-borne diseases and that improvement of water supply facilities was therefore a matter of basic importance in combatting this group of diseases. Detailed plans have been laid and municipal funds already made available for the construction of improved water supply systems, under the supervision of WHO experts, in Nanking, Hangchow, Changsha, Lanchow, and Hsining.

Ethiopia Mission

Ethiopia's staggering health problems, particularly a venereal disease rate estimated as high as 80 per cent, in some areas, are the subject of a special study being carried out by experts of WHO-IC at the request of the Ethiopian Government. Dr. N. Goodman, Director of Field Services for WHO-IC, left Geneva for Addis Ababa early this month to inspect the work of Greek, Canadian, British, and United States public health specialists operating in Ethiopia since 1 January 1947, when the program was transferred from UNRRA to WHO-IC. Accompanying Dr. Goodman is Dr. T. Guthe, WHO-IC Advisor on Venereal Diseases. Later this spring Dr. D. R. Thomson, prominent TB specialist and Deputy Chief of the WHO-IC mission to Greece, will follow.

These officers will assess the extent of the TB and VD problem among the 12 to 15 million people of Ethiopia and advise the Health Ministry on methods of combatting these diseases, considered the most serious health menaces among many others. Ethiopia's situation is made particularly difficult because of her lack of trained personnel. Of the 137 Ethiopians educated outside the country before the Italian occupation only 35 have survived. In the health field, for example, there is only one Ethiopian doctor, now too old to practice, only one qualified Ethiopian nurse, and only one Ethiopian sanitary inspector.

The country must depend for most of its health services, during the next ten years at least, on a very limited number of foreign professional personnel. Hence the main task of the WHO mission has been to train Ethiopian sanitary inspectors and hospital "dressers"—men or women at least partially acquainted with the elements of hygiene and the care of the sick.

Recent reports from the Ethiopian mission state that 94 students have been graduated from the four primary courses for dressers in the country. One advanced course is now under way in the capital. Some 24 students are enrolled in two or three primary courses in provincial hospitals. Primary certificates have been granted to nearly 40 Ethiopian sanitary inspectors trained by the WHO Sanitary Engineer; and a secondary course in this subject is under preparation.

In addition, health films are being shown regularly in schools and to the personnel of the Ministry of Health. The WHO Chief Nurse has taken a leading part in re-establishing the Ethiopian Red Cross, which works closely with the Ministry. She has also organized a Red Cross course in home care of the sick for Ethiopian volunteer workers.

Under the direction of the Sanitary Engineer a survey of environmental hygiene in Addis Ababa was completed, and recommendations were drawn up for emergency and routine measures to be employed. The mission was instrumental in establishing permanent delousing stations in the capital. Extensive field trials were made of mosquito larval control, and a malaria survey of Addis Ababa and vicinity is scheduled to begin shortly.

Italy Mission

With the recent arrival of 300 tons of DDT, a large-scale anti-malaria campaign for Italy during 1948 and 1949 is now being shifted into high gear, according to reports from the WHO-IC mission currently advising the Health Ministry in Rome. In addition to the fight against malaria, WHO-IC medical liaison officers are assisting the Italian health authorities in tuberculosis control, in the rehabilitation of port sanitation services, in programs for maternal and child care, in working out details for the construction of a penicillin plant, as well as in many other fields.

One of the top-priority projects, however, is the drive against the malaria-bearing anopheline mosquito. An all-out drive to wipe it out completely by the end of 1949 is already under way in Sardinia, with energetic control measures contemplated for Sicily and the mainland. In Sardinia the program began early in 1947. Preliminary work was completed during the first nine months of that year. Then, on last October 8, the campaign to deliver the knock-out blow was launched. It consists of: (1) a final island-wide campaign of DDT residual spraying to kill hibernating adult mosquitoes; (2) killing mosquito larvae in every possible breeding place on the island, on a 7-day schedule; (3) quarantine and mosquito control services to be developed during 1948 and 1949.

There are some 40,000 recorded cisterns and springs on Sardinia. These will be checked during the campaign to kill larvae, and new or unrecorded breeding places will be added to this list. DDT spraying teams are treating all buildings and other places where mosquitoes shelter, including caves. Three fog-spraying machines have just been acquired for use in large buildings, in swamps, and on shipboard.

To avoid fresh importations of mosquitoes, ships and aircraft will be sprayed with DDT on arrival. Districts surrounding ports and airfields are to receive a special drenching with DDT at 3-month intervals.

As a result of the malaria control program on the Italian mainland and in Sicily, the mission reports that only 30 deaths from malaria were recorded in 1947 for the whole area, as compared with 250 in 1946 and 360 in 1945.

Greece Mission

An emergency program to improve health conditions in the Dodecanese Islands, recently returned to Greek control after 400 years under foreign rule, has been mapped by representatives of WHO-IC's Mission to Greece. According to Dr. J. M. Vine, who was responsible for a survey made in recent weeks, tuberculosis is the most serious health problem on the islands. An extensive program of organizing health centers, dispensaries, etc., on the main islands of the Dodecanese group is immediately necessary. It is planned now to set up a Public Health Center, with five clinical sections on the three islands of Rhodes, Cos, and Colymos, as well as a mass x-ray program for Rhodes.

In addition to TB, malaria was an extremely serious problem until very recently. But in 1947 DDT was introduced by WHO and four sanitary inspectors were instructed in its use, with the result that the incidence of malaria has been reduced by more than 80 per cent.

In Greece proper, meanwhile, forty-five tuberculosis dispensaries and two mass x-ray centers have now been put into operation under the tuberculosis program. Twenty-two of these dispensaries are located in Athens and 23 in the outlying provincial areas. Despite the efforts of the Greek staff, however, and of the WHO mission only 25 of the 45 dispensaries are reported to be functioning satisfactorily. Economic difficulties, lack of trained personnel, and the civil war are continuing to hamper the health program in Greece.

In the mass x-ray centers in Athens and Salonika, more than 100,000 chest examinations have been made and an analysis of these cases is now in preparation, the WHO tuberculosis specialist reports. Clinically significant pulmonary tuberculosis for urban districts remains approximately 3 per cent. An appropriation of 54 million Drachmae, or about $6,000, from the Greek War Relief Association in the U. S. supplemented the public funds for this enterprise, thus overcoming the greatest stumbling block.

The first semi-rural center for mass x-ray is now being installed in Elefsis Sanatorium. WHO-IC personnel are helping to operate it during the first three months and are training a Greek staff to continue the work.

Col. D. E. Wright, WHO Chief Sanitary Engineer, who is in charge of the malaria and sanitation programs, has announced the purchase of additional aircraft, with spares and repair parts, for use in DDT spraying. This technique will be used to control not only the larva of malaria-carrying mosquitoes, but also the dakus fly, which may cause losses of up to 60 per cent of the olive crop. Twenty-five planes will be available in 1948 for this combined program which, if internal conditions permit, should make it possible to render a service to the country unequalled in any country in the world, according to this report.

HOMES FOR ILLEGITIMATE BABIES IN OCCUPIED GERMANY
(French Zone)

Dr. G. Montreuil-Straus

EVERY NEW WAR seems to bring forward new problems. After the tragedies of executions and deportations, the horrors of Nazi concentration camps, the long Calvary of a five years detention for our prisoners of war (1940-45), we must now concern ourselves with the illegitimate children for whom the occupation troops in Germany are responsible.

This problem is not specifically a French one. It exists with the same acuity in the British and American occupation zones. But as President of the Women's Medical Service Committee, created in France to co-operate with the American Wom-

Dr. Marie Helmer, pediatrician. Dr. Helmer served with the resistance movement in France during the war. After the liberation, she was employed by the Comité Féminin de Service Médical as A.W.H. doctor in charge of the medical service in the COSOR (Comité des Oeuvres Sociales de la Resistance) orphanges on the outskirts of Paris. She has recently been selected by Dr. Boide, Inspector General of Public Health, to organize homes for illegitimate children born in the French Zone of Germany of French or Allied fathers and German mothers.

en's Hospitals in the help of war victims, especially children, I wanted, in the name of the American Women's Hospitals, to make a short visit to the French occupation zone in order to realize the conditions of life of these poor little waifs who are, unfortunately, in one of those numerous categories of modern war victims.

As I could spare only three days for this trip, I thought I would be able to visit the three babies homes situated in the area of Baden-Baden, Karlsruhe, and Spire. A snowstorm struck me at the Nordrach babies' home, Black Forest, south of Baden-Baden. Thus, I shall talk more specifically about this one, but the information about the medical service for abandoned children was given to me by Dr. Helmer, head physician of this baby home and inspector of the two others.

When the French troops arrived in Germany, a P.D.R. Commission (prisoner, deportee, repatriate) searched in every town and commune for French deportees and workers of both sexes as well as for the children born of their union with a German partner. Children of all ages, without parents, were sent to Unterhausen near Tubingen, and the smallest children to babies' homes in Bad Turkheim and Appenthal. The oldest went to France to children's homes belonging to the Public Health Service. The youngest remained in the babies' homes in Germany where they are to be kept until they can be evacuated to France. But the birth of illegitimate children of French or allied fathers and German mothers still necessitates the maintenance of the babies' homes.

The taking over of a child is done in the following manner: When in a village a child is presumed to be of French origin, the Burgemaster notifies the office of the P.D.R. An inquiry is made. If it seems conclusive and if the woman is decided on abandoning her child, she signs a certificate in three copies asserting that her child's father was French (or allied) and that she will abandon it. Following this, the child is put in a German Kinderheim until it is taken over by a French babies' home.

In 1947 Dr. Boide, Inspector General of Public Health, asked Dr. Marie Helmer, director of the American Women's Hospitals Service in the COSOR Children's Homes in France, to leave for Germany in order to take over the supervising of the three babies' homes and to organize and direct a new home in the former Rothschild sanatorium at Nordrach. This is in a very picturesque part of the Black Forest at a height of 400 meters. During the war it was used by the SS maternity services and later occupied by the troops and extensively damaged.

When Dr. Helmer reached Nordrach, she found an empty house which she organized. The building has four stories, each story being made up of rooms for children under four years. In each room there is warm and cold running water, with a small bath, a swaddling table, a large wall cupboard. At each story are annexes with patients' kitchen, bathroom, isolation ward for emergency cases. An elevator connects all the stories. The feeding-bottle room, with sterilizer, is quite modern; near by is a cold room used only for the feeding bottles. There is also a big playroom for the older children, a terrace, and a beautiful park with fir trees.

On Dr. Helmer's arrival there were 30 children, from six months to four years old, in Tubingen, about 40 children at Bad Turkheim, and 42 children under 18 months and 4 older ones in Appenthal, former maternity for SS, very well equipped with cubicles for sucklings.

The first children brought to Nordrach were from Tubingen, a badly kept house where the children were in poor condition. Then came the babies from the German Kinderheims who were waiting for their turn to come to French babies' homes. At the present time there are in Nordrach 69 children, 10 being over two years old, 40 over one year, the rest being under one year. Amongst them are three half-bred Negroes, three children of Arabian blood, and two probably of Indochinese blood.

Dr. Helmer's opinion is that two out of the three homes ought to be emptied, beginning with Bad Turkheim, the less well organized and well kept, then Appenthal, so as to have only Nordrach where 100 children can be kept. The two-year-old healthy children could be sent to France.

At Nordrach the head is Dr. Helmer, who is also medical inspector of the two other babies' homes. There are one administrative officer, four Red Cross nurses, one teacher in charge of the kindergarten, one secretary, one driver with a car. The rest of the babies' home staff are qualified German *schwesters,* night nurses, kitchen employees, housemaids, sewing maids. As a rule they are efficient. None of the German staff is fed, except the cook and her assistants. The others have workers' food cards and live in a home where they have their meals. The supplies come from the Kreis Food Office, which supplies all French military and civilian employees.

The health situation was excellent when I went to Nordrach. There had been five deaths during the children's quarantine and two more six weeks after their arrival. These children had been badly looked after and were suffering from athrepsia, rachitis, and abnormal metabolism. Since these deaths there have been one case of diphtheria and a few cases of pneumonia. The sick but noncontagious children are treated in the home where they can be easily isolated.

The children receive no vaccination in the German Kinderheims. They arrive at the babies' homes without any information and often in a poor condition. Consequently, on their arrival they are submitted to throat swabbing, anti-variolous vaccination, anti-diphtheric vaccination, which sometimes is the first one given on account of the great number of diphtheria cases in Germany. Every three months, a "cuti" is made. The American Women's Hospitals provides Dr. Helmer with funds to buy drug supplies she needs and which she cannot get in the semi-military drug stores of the occupation zone.

The impression given by the Nordrach babies' home is encouraging. But what will be the future of these little waifs?

It seems that the best would be, when they are big enough to leave the home and be sent to France, to place them in a home similar to the COSOR children's homes in which the A.W.H. is interested, supervised by the Public Health Services, and where efforts would be made to have them adopted. But the organization of such a home sets many problems. If the A.W.H could take charge of the medical and nursing service of such an institution, it would perhaps be possible to organize it.

In any case, the existence and management of French babies' homes in the occupied zone, first step towards the assistance to illegitimate and abandoned childhood which is the result of the allied occupation in Germany, deserves to be known and I am glad to have been able to conduct this inquiry in the name of the American Women's Hospitals.

COMITE FEMININ DE SERVICE MEDICAL
(WOMEN'S MEDICAL SERVICE COMMITTEE)

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Journal of the
AMERICAN MEDICAL WOMEN'S ASSOCIATION

ORGANIZATION

PRESIDENT'S MESSAGE

WE GROW

DAY BY DAY we rise, fill our hours with humdrum duties, or catch the occasional opportunity to mark an illuminating moment. The mirror shows but little change in our features from day to day. Year to year the camera reveals the slowly evolving changes.

The annual meeting is the yearly camera which reveals the culmination of the small changes we make in our Association. It is also the projector through which we view our aims for further development.

The social pattern of the entire world now is built upon the policy of the united efforts of group interests pushing forward toward future goals. Women physicians urgently need to unite to further whatever interests us. Our need is to simplify our mechanisms and to elevate the goals toward which we strive.

This is the final message that I shall issue as President of your Organization. To each one who reads this I offer personal thanks, in that you are a member. By that much you have contributed to the upward progress of other women in the profession. This, together with whatever else you have done this year is appreciated. By our daily fidelity to the goal of advancement we DO GROW.

MABEL E. GARDNER, M.D.

RESOLUTION REGARDING THE WORLD HEALTH ORGANIZATION

We have recently learned that the Rules Committee of the House of Representatives has voted to table the Bill authorizing the United States to become a signatory to the World Health Organization.

Because it is of the utmost importance that the United States become a Charter Member in the World Health Organization, the following resolution is presented for approval by the American Medical Women's Association:

"Whereas: the World Health Organization of the United Nations will be one of the most important agencies in promoting world peace as well as in promoting world health and thus in protecting the health and welfare of the United States, and

"Whereas: the United States was a leader in the formation of the World Health Organization at San Francisco in 1945, and signed the constitution in New York in 1946, and

"Whereas: the United States Senate in 1947, passed a bill to make the United States a signatory to the WHO, and the Committee on Foreign Relations of the House of Representatives approved a similar bill recently, and

"Whereas: the Rules Committee of the House of Representatives on March 12, 1948 voted to table this bill indefinitely, thus preventing action by the House, and

"Whereas: if the recent action of the Rules Committee stands, the United States will not become a charter member of the WHO, and will not be able to participate officially in the formulation of a world health program, therefore

"Be it resolved: that the American Medical Women's Association urge the Rules Committee to rescind the above action, and to place the bill before the House for immediate action, and

"Be it further resolved: that the Secretary of the A.M.W.A. be instructed to transmit a copy of this resolution to each member of the Rules Committee, and to the Speaker, and Majority Leader of the House of Representatives."

Luella E. Nadelhoffer, M.D., Chairman,
Public Relations Committee, A.M.W.A.

PROGRAM OF ANNUAL MEETING

Blackstone Hotel, Chicago—June 19-20, 1948

Friday, June 18

8:00 p.m. ..... Executive Committee Meeting
Reference Committee Meeting

Saturday, June 19

8:00-9:00 a.m. ..... Registration
9:00-12 Noon ..... Annual Business Meeting
12:30 p.m. ..... Luncheon (informal). Speaker to be announced.
2:00-5:00 p.m. ..... Annual Meeting, continued
7:30 p.m. ..... Annual Banquet. Speaker: Elise S. L'Esperance, M.D., incoming president

Sunday, June 20

9:00-11:00 a.m. ... Called Meetings (to be announced)
11:30 a.m. ..... Brunch
2:30-3:30 p.m. ..... Quiz Kids Broadcast
4:00-6:00 p.m. ..... Tea at home of Frances Hannett, M.D., 5490 South Shore Drive, Chicago

Chairman of Local Committee

Katharine Wright, M.D., 25 East Washington St., Chicago 2, Illinois
Luncheon, June 19 ..... $3.50
Banquet, June 19 ..... $5.75
Brunch, June 20 ..... $3.00

Send check with reservations for the above to Dr. Katharine Wright, Chairman of local Arrangements, 25 East Washington Street, Chicago, Illinois.

NEWS FROM THE BRANCHES

Fifteen, Cleveland

This Branch now has sixty-two members. The officers for 1948 are: President, Helena Hoelscher, M.D.; Vice-President, Rose Petti, M.D.; Secretary, Elizabeth Lash, M.D.; Treasurer, Edith Brown, M.D.;, Program Committee, Ruth Robishaw M.D., Chairman.

Six dinner meetings are held each year, two of them purely social. The September meeting was held at the home of Dr. Hoelscher, and the Christmas party at Dr. Glover's. At the October 1947 meeting, Dr. Stanley Goldhamer gave an illustrated talk on Macrocytic Anemia, and the following month Dr. Anna Young of Mount Sinai Hospital spoke on the Rh factor. The February 1948 meeting was most interesting, the program being arranged by members who are house officers in the local hospitals. Papers were given by: Dr. Gertrude Leibel, City Hospital, Infections by gas forming bacilli; Dr. Charlotte Ames, University Hospitals, Bichloride poisoning: Treatment with British anti-leuicite substance; Dr. Sara Sykes, Fairview Park Hospital, Case of bichloride poisoning; Dr. Mary Thomas, Huron Road Hospital, Obstructive jaundice caused by tumor; Dr. Alyce Lipscomb, Resident, Cleveland Clinic Hospital, Case of blastomycosis.

Sixteen, Pittsburgh

At the regular monthly meeting of the Pittsburgh Branch, held February 17, 1948, the following officers were elected for the coming year: President, Dorothy Nash, M.D.; Vice-President, Theodora Dakin, M.D.; Recording Secretary, Florence Gordon, M.D.; Censor, Rachel Weems, M.D.

Two, Chicago

Because of the fact that many of our members wished to attend the Annual Clinical Conference of the Chicago Medical Society, March 2 to 5, no regular meeting of Branch Two was held in March. The regular meeting was held on April 14 at Wesley Memorial Hospital. The guest speaker, Dr. Madge T. Macklin, delivered an address on the aspects of research in human breast cancer. Dr. Macklin is Research Associate and Lecturer in Genetics in the Medical Department of Ohio State University.

The State medical meeting was held May 10, 11, and 12 at the Palmer House. Dr. Nadelhoffer, our president, acted as chairman for the Annual Breakfast which the State Society sponsors for the women members.

NEW LIFE MEMBERS

***258—Ruth Ellis Lesh, M.D., Arkansas. (Already Member.)**

NEW ACTIVE MEMBERS

CALIFORNIA

Jessie M. Bierman, M.D.—School of Public Health, University of California, Berkeley 4, California. M.D., Rush, University of Chicago, 1927; M.P.H., Columbia. Member of Specialty Board. Specialty: Pediatrics. Endorsed by Drs. Dorothy Atkinson and Martha Eliot.

Louise J. Gordy, M.D.—6255 Van Nuys Blvd., Van Nuys, California. M.D., New York University—Bellevue Medical College, 1927. Member of A.M.A., County Medical and American Psychological Association and New York Society of Clinical Psychology. Specialty: Neurology and Psychiatry. Endorsed by Drs. Gertrude C. Seabolt and Elizabeth A. Sirmay.

DISTRICT OF COLUMBIA

Mary K. L. Sartwell, M.D.—1211 Jefferson St., N.W., Washington 11, D. C. M.D., George Washington University, 1944. Member of D. C. Medica and George Washington University Medical Society. Specialty: Pediatrics. Endorsed by Drs. Dorothy Jaeger-Lee and Carolyn S. Pincock.

FLORIDA

Vlasta H. Drahos-Uzell, M.D.—158 N.E. Fifth Street, Miami 36, Florida. M.D., State University of Iowa, 1911. Specialty: Women's Diseases. Endorsed by Drs. Lydia Allen DeVilbiss and Iva C. Youmans.

Genevieve Gustin, M.D.—Starke, Florida. M.D., Woman's Medical College of Pennsylvania, 1903. Member of County Medical. Specialty: Psychiatry.

ILLINOIS

Anne Bohning, M.D.—5844 Stony Island Avenue, Chicago 2, Illinois. M.D., University of Vienna, sity of Chicago, 1926. Member of A.M.A., Chicago Medical and Central Society of Clinical Research. Specialty: Cardio-vascular. Endorsed by Drs. Luella E. Nadelhoffer and M. Alice Phillips.

Marie P. Tamas, M.D.—123 West Madison Street, Chicago 2, Illinois. M.D., University of Vienna, 1930. Member of A.M.A., County Medical and Institute for Psychoanalysis. Specialty: Child-Psychiatry, Psychoanalysis. Endorsed by Drs. Joan Fleming and Charlotte G. Babcock.

MARYLAND

Evelyn Anderson, M.D.—National Institute of Health, Division of Physiology, Building 3, Room 204, Bethesda 14, Maryland. M.D., University of California, 1928. Ph.D., McGill. Specialty: Research in Endocrinology. Endorsed by Drs. Dorothy W. Atkinson and Ellen Brown.

Margaret E. Callan, M.D.—8491 Rockville Pike, Bethesda, Md. M.D., George Washington University, 1944. Member of AMA, County Medical, George Washington Medical Society, and American Society of Anesthesiologists. Specialty: Anesthesia. Endorsed by Drs. Eloise W. Kailin and Dorothy Jaeger-Lee.

Mary Lodema Hayleck, M.D.—229 East 33rd St., Baltimore 18, Md. M.D., University of Maryland, 1938. Member of Baltimore City Medical Society.

Specialty: Pediatrics. Endorsed by Drs. Eleanor Scott and Lucile J. Caldwell.

NEW YORK

Annie Belle Lo Grippo, M.D.—111 Nassau Boulevard, Garden City, Long Island, New York. M.D., Medical College of Virginia, 1939. Member of A.M.A. and County Medical. Specialty: Office Gynecology.

OHIO

Mabel Richards Tarbell, M.D.—691 Bryden Road, Columbus 5, Ohio. M.D., Ohio State, 1908. Member of A.M.A., State and County Medical and Columbus Academy of Medicine. Specialty: Psychiatry. Endorsed by Drs. Frances Keller Harding and Emilie C. Gorrell.

PENNSYLVANIA

Laura Evelyn Hill Kremer, M.D.—Morrisdale, Pennsylvania. M.D., Hahnemann Medical College, 1944. Certificate, University of Pennsylvania Graduate School of Medicine. Member of County Medical. Specialty: Gynecology-Obstetrics.

Jane M. Leibfried, M.D.—212 West Chelten Ave., Philadelphia 44, Pa. M.D., Woman's Medical College, 1941. Member of AMA, County Medical and Philadelphia Obstetrical Society. Specialty: Obstetrics and Gynecology. Endorsed by Drs. Frieda Baumann and Elizabeth I. Waugh.

SOUTH CAROLINA

Edith Eskrigge Haynes, M.D.—1412 Bull Street, Columbia, South Carolina. M.D., Tulane, 1933. Member of A.M.A., Columbia Medical and South Carolina Medical. Specialty: Women & Children. Endorsed by Drs. Jane Bruce Guignard and Katharine Baylis MacInnis.

NEW ASSOCIATE MEMBERS

Winifred R. Smith—421 S. 42nd Street, Omaha 3, Nebraska. M.D., University of Nebraska, 1948. Endorsed by Elinor E. Marsh, M.D.

Charlotte Ames, M.D.—University Hospitals, Cleveland 6, Ohio. M.D., Western Reserve University, 1947. Member of Alpha Omega Alpha. Endorsed by Drs. E. P. Brown and Faith Reed.

Jeanne E. Kehoe, M.D.—11123 South Hermosa Avenue, Chicago 43, Illinois. M.D., University of Illinois, 1947. Member of AMA. Endorsed by Drs. Carroll L. Birch and Beulah Cushman.

Betty Markscheid Sobol, M.D.—321 Mt. Prospect Ave., Newark, N. J. M.D., New York University, 1944. Member of County Medical. Endorsed by Drs. Sara D. Swalley and Mildred G. Gregory.

READMISSIONS

Iva G. Murphy, M.D.—1314 Mass. Ave., N.W., Washington 5, D. C. M.D., University of Illinois, 1935. Member of AMA and Escambia County Medical Society of Alabama and A. P. H. A. Specialty: Public Health. Endorsed by Drs. Cecile L. Fusfeld and Elizabeth Kittredge.

AMERICAN MEDICAL WOMEN'S ASSOCIATION, INC.

APPLICATION FOR MEMBERSHIP

Name .....
(Please print, as you wish it to appear in the Year Book.)

Address .....

Medical School ..... Year of Graduation .....

Licensed in County ..... State .....

Specialty ..... Certified .....

Place of Birth .....

Date of Birth ..... Marital Status .....

To what Medical Societies do you belong? .....

Check Membership desired:

☐ National — Dues $5.00 yearly, payable January 1st.

☐ Branch — Dues prescribed by Branch, and are not included in the above.

☐ Life Membership — $100.00. (Payable in two installments, if desired.)

☐ Memorial — $500.00.

☐ Associate, no dues.

☐ If member-at-large check here.

Annual, Life and Associate members receive the official publications. Annual and Life members receive membership in the International.

Endorsed by: 1. ..... M.D., Member A.M.W.A.

2. ..... M.D., Member A.M.W.A.

(Membership in County or State Medical Society may be accepted for above endorsements.)

Date ..... Signature .....

Checks must accompany application. Mail to Treasurer: Mary Riggs Noble, M.D., Bowmansdale, Cumberland County, Pennsylvania. Make checks payable to American Medical Women's Association, Inc.

Public Relations Department

OPPORTUNITIES FOR WOMEN IN MEDICINE

A Talk to Undergraduates

ELAINE P. RALLI, M.D.

Stimulating women undergraduates to be interested in medicine as a profession has been a project of the Women's Medical Association of New York City. Several of the members have visited colleges and have talked to the women students in groups and in assembly. The following talk was given recently at Vassar College by Dr. Elaine P. Ralli, President of the Association and Associate Professor of Medicine, New York University College of Medicine. We are glad to have the opportunity to publish this article because it stresses not only the opportunities but also the responsibilities of the woman student in medicine.

I VERY MUCH APPRECIATE discussing the subject of opportunities for women in medicine. However, I would like to make it clear that I am really speaking about opportunities in medicine for both men and women. Since women first went into medicine in this country, discrimination against them has been steadily decreasing, and now there is very little antagonism towards women doctors and their opportunities in the field are excellent. There are, of course, certain people who will always have reservations about women in professions, but they probably have reservations about almost everything! By and large, the opportunities in medicine today are almost equal for men and women, and I think that such opportunities will continue if the caliber of the women going into the profession remains high.

It is important, however, for a woman to realize that if she is enrolled in a medical school, it is imperative that she complete her studies. Medical schools are limited as to their facilities and can only admit a very small proportion of the total number of students applying for entrance. For this reason if a woman enters medical school and then drops out it causes a certain amount of annoyance to the institution because it is felt that another student was denied the opportunity of a medical education. Therefore, when you plan to marry and have children, it is merely necessary not to allow this to interfere with the completion of your courses.

Medical education brings an unequalled opportunity for acquiring a broad and humane back ground. It is an experience in education that is unique, and to an inquiring individual it seems to me to offer more avenues than almost any other educational training. To begin with, there is the technical and scientific aspect of the education. You must acquire many facts, and not in any casual way, because you must have these facts at your complete command so that you can use them at a moment's notice. The discipline required by this type of training will stand you in good stead under many circumstances, and it increases your mental capacities. I do not mean to infer that other professions do not demand the accumulation of facts in an orderly way; but the physician must be doubly sure of his knowledge because an error in his judgment involves the life of an individual.

Among the first sciences that you are trained in, is anatomy. This is a science that is very much alive and as you study the mechanics of the body, you do so in a variety of ways—structurally, physiologically, and biochemically. Thus you not only learn the insertion of muscles and their innervation, but you learn the changes that go on within the cell when the muscle contracts. This affords you training in the co-ordination of knowledge, and this type of learning keeps expanding. For example, you realize that for a cell to perform its functions it has to have substances from which it can derive its sources of energy, which it does from the foods that are eaten. As you become interested in nutrition, you become interested in the source of food supplies, the soil that food is grown on; the diet of animals as well as of individuals becomes of interest to you. In other words, you keep going further and

further back for your information, and in this way the profession gives you a unique opportunity for broadening your intellectual capabilities.

Then there is the training in the sociological aspects of medicine, in the problems of people's lives—economic and emotional—and the effects of these upon disease.

You come to look at history from a different point of view. You learn to realize that the course of history is often influenced by the physical state or stamina of the individual, and this in turn may be affected by either famine or by epidemics. You will find that when you are travelling around you are much more interested in the countryside and in a greater variety of ways.

The profession of medicine has its picturesque side also. There is an atmosphere about it that is dramatic and many of the situations in which you find youself are as exciting and interesting as any book that you will ever read. Then you have unlimited contacts, both with patients and with the other members of your profession. If you work in the city hospitals, you will meet people from every stratum of society and you will find that life has facets that you had never imagined. A whole new point of view on living is developed in this way, and you have to grow if you are to fulfill your potentialities. Personally, I think one feels indebted for this chance, because only by understanding the problems of people of all kinds can you appreciate the complexities of life. And then there is the association with your fellow physicians, which provides a unique form of comradeship between men and women and a friendliness that I have never heard of in other professions. It goes beyond the boundaries of nations, and at international congresses doctors can somehow separate themselves from the antagonims bred by nationalities.

As far as absolute practical opportunities are concerned, once you have finished medical school you can go into research, into teaching, into practice, or into a combination of these. The specialties in medicine provide endless opportunities. The new interest in chronic diseases is creating more and more opportunities for doctors. The Public Health Service of this country is providing grants for research which make it possible for the young physician to develop himself. Teaching in medicine is unlike teaching in college because the student is going into the same profession as the teacher, and so you have a very free exchange of ideas and a common interest. The doctor almost always does some teaching, either officially in a medical school or less didactically in his hospital work or in the clinic.

Today the demand for doctors does not equal the supply, and I think that the opportunities in medicine and its allied fields will continue to grow.

In your undergraduate work you should get the required sciences. But I would caution you against inundating yourself in sciences before you enter medical school. Particularly do not restrict yourself to just chemistry and physics. You have here a Department of Plant Science which can give you some very interesting information on subjects that you will have real occasion to use later on. When I was here I took a course in geology. As it happened, I have been interested in diseases of the thyroid, so that I found myself very interested in the various glacial periods and their effect on the iodine content of the soil. I wished then that I had had more geology or paid more attention to it! Now is your chance to get a really broad background—a background that will make it possible for you to use your leisure intelligently and to understand all kinds of people. There is no course that you can take that will not help to broaden your point of view, but I urge you to be well informed on history, to get a good literary background, to know something of the arts, and to have one or more foreign languages at your command. Many things will enter into your development, but a good general education to start with is of tremendous value.

I said to you at the outset that there is nothing casual about medical school—there is nothing casual about the profession of medicine. You must be prepared to work hard and you must develop a capacity for sustained work. You should not think of entering the profession of medicine unless you really understand that it requires consistent effort on your part. The work is, however, so interesting that a good deal of the time you hardly think of it as work; and as you continue to train your brain cells, they respond by increasing their capabilities.

You are contemplating a profession which requires hard, consistent work and the more you put into the profession of medicine the more you seem to get out. You will have an unparalleled opportunity for a broad education, you will have the additional opportunity of making life more reasonable for other human beings, and you will find that you yourself have developed a more generous attitude of mind.

Opportunities for Medical Women

Teaching and Research Fellowships in Tuberculosis

Establishment of a number of teaching and research fellowships in the field of tuberculosis by the National Tuberculosis Association has been announced by Dr. Esmond R. Long, director of the NTA's Division of Research. The action was recommended by the executive committee of the NTA's Medical Section, the American Trudeau Society.

Annual stipends for the fellowships will range from $2,400 to $3,200, according to Dr. Long. Provision will also be made for laboratory fees and incidental expenses of like character.

The fellowships will be limited to graduates of American schools for teaching and investigation in the United States. While preference will be given to applicants with a Doctor of Philosophy or Doctor of Medicine degree, fellowships will not be restricted to the holders of these degrees.

Applications will be considered in the fields of pathology and bacteriology, clinical medicine, epidemiology and social and statistical research. Applicants may elect the institutions in which they wish to study.

Persons interested in obtaining a fellowship should write to Dr. James E. Perkins, managing director National Tuberculosis Association, 1790 Broadway, New York 19, N. Y., for further information.

Industrial Psychiatric Fellowship

A pioneer program to train psychiatrists for the industrial relations and labor field will be inaugurated at Cornell University with an industrial psychiatry fellowship offered in the School of Industrial and Labor Relations. The Carnegie Corporation has made a supporting grant. The fellowship will be awarded to a physician with experience in psychiatry and will provide two years of training at the school. In addition to classroom study in basic industrial and labor relations courses, the fellow will receive training in human relations work in a plant, labor union or government office.

The Koessler Fellowship

The Jessie Horton Koessler Fellowship of the Institute of Medicine of Chicago for the aid of research will be available on September 1, 1948. The stipend is $500 a year with the possibility of renewal for one or two years. Applications will be received until July 1, 1948 and should be sent in quadruplicate to Dr. Paul R. Cannon, chairman of the committee, 950 East Fifty-Ninth Street, Chicago.

Fellowships on Pathology of Tumors

Through the W. T. Grant Foundation, fellowships on the pathology of tumors are available in the laboratories of Memorial Hospital for the Treatment of Cancer and Allied Diseases. Requirements are that a candidate shall hold appointment as assistant professor or instructor in a university department of pathology and that he shall be given a one year leave of absence with a guarantee that he may return to academic status after completion of the fellowship. These fellowships are designed for training of personnel of universities which have received government grants for establishment of correlated work in the teaching of cancerology. Students will have access to about 18,000 specimens per year and will attend conferences and follow-up clinics. Research may be undertaken as a minor portion of the program provided it forms a part of one of the research programs being conducted in the institution. The annual stipend of $5,000 may be supplemented by the university in any individual case. Application should be made to Dr. Fred W. Stewart, Memorial Hospital, 444 East Sixty-Eighth Street, New York 21.

Fellowships in Public Health Available Through the New York State Department of Health

Dr. Herman E. Hilleboe, New York State Health Commissioner, announces the availability of Fellowships for young physicians interested in entering public health as a career. The Fellowships are for a period of two years or less, depending upon the qualifications of the applicant. Both field training and academic training leading to a Degree of Master of Public Health are given during the period of the Fellowship, which carries with it a stipend of $3,600 per year. In addition, necessary travel and other expenses are paid as well as tuition at a school of public health.

Application blanks and further information may be obtained by writing to Dr. Franklyn B. Amos, New York State Department of Health, Governor Alfred E. Smith State Office Building, Albany 1, New York.

Fellowships in Child Guidance Clinic Psychiatry

The American Association of Psychiatric Clinics for Children is offering fellowships for training in child guidance clinic psychiatry under the auspices of the U. S. Public Health Service, the Commonwealth Fund and some local funds. The training is for positions in community clinics where psychiatrists, psychologists, social workers and others collaborate in the treatment of children with emotional or mental illness. Most of the fellowships are for two years, some for one. The stipend is $3,000 for the first year, more for the second. Prerequisites are graduation from an approved medical school, a general internship and two years of general psychiatry. Opportunity is provided for the fellow to develop his own skills in an out-patient service with the support of a carefully planned training program and adequate supervision. The training centers are selected on the basis of standards which have been established by the association, and the fellowships are awarded by a committee of this organization. For information write Dr. Abraham Z. Barhash, executive assistant, the American Association of Psychiatric Clinics for Children, 1790 Broadway, New York 19.

Training Fellowships in Public Health Education Offered

Fellowships for graduate study in public health education, previously administered by the United States Public Health Service, are now being administered by the National Foundation for Infantile Paralysis. Fellowships amount to $100 a month, plus tuition, as well as certain fees and transportation, in connection with field work. Partial fellowships are available to veterans to supplement amounts for maintenance under the G. I. Bill of Rights.

Applicants must be between the ages of 22 and 40, inclusive, must be citizens or must have applied for citizenship. Also required is an A.B. or B.S. degree plus some additional qualifications such as a master's degree, three years' experience in the field of public health or an allied field or other evidence

of special interest. State and local health department employees are not eligible.

Students accepting fellowships must agree to complete the school year, and in addition three months of field training, and accept employment in the United States or its territories.

Candidates should write for application blanks to: Credential Secretary, Division of Professional Education, National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

Sixteen Scholars in Medical Science Announced By Markle Foundation

Sixteen young scientists have been appointed as the first group of Scholars in Medical Science, under the plan announced last fall by the John and Mary R. Markle Foundation to support qualified young scientists who wish to make a career in academic medicine. The Scholars were selected from candidates nominated by accredited medical schools in the United States and Canada by regional committees appointed by the Foundation. Toward the support of the Scholars and their research the Foundation has allocated a total of $400,000 to their respective medical schools, each school to receive $25,000 payable at the rate of $5,000 annually for five years.

As faculty members of the participating medical schools, the Scholars will devote the next five years to teaching and research, at the end of which time they will have had an opportunity to become established teachers and investigators. According to John M. Russell, Executive Director of the Foundation, an undetermined number of Scholars will be appointed each year for the next few years for the long-range purpose of strengthening the faculties of medical schools, and medical education generally.

(*We hope that in future announcements we may see the names of some of our young medical women listed among those receiving appointments.*—ED.)

Current Publications of Women in Medicine

Macandrew, Maureen, and **Davis, E.:** Trichiniasis presenting with foot-drop and facial palsy. Lancet *1:* 141, Jan. 24, 1948.

Case report showing that trichiniasis should be considered in the differential diagnosis of unexplained neuritis in England.

Warburg, Bettina: Health Examinations: A Handbook for the General Practitioner. Chapter X-B. Emotional Factors in Senescence. New York Med. *4:* 19-20; 30, Jan. 20, 1948.

The emotional problems of persons over 65 years of age are of a very special character and often have a distinct bearing upon their physical condition. In this group the accent falls primarily upon the immediate life situation. The emotional prerequisites are dominantly of two kinds: 1. To feel necessary where they were previously active; 2. To be loved and if need be, to be taken care of. The outbreak of a true psychoneurosis in old age is comparatively rare, whereas psychotic states are frequently seen.

Lloyd-Green, Lorna: Some aspects of female infertility. M. J. Australia *1:* 7-12, Jan. 3, 1948.

This is a general discussion of the examination of patients (history taking, gynecological examination, physical examination, psychiatric survey), diagnostic tests, and treatment and results of treatment. Author concludes that although much has been learned our knowledge is still in its infancy and much research is still required.

Bubert, H. M., and **Cook, Sarah:** Status asthmaticus. South. M. J. *41:* 146-150, Feb. 1948.

(From the Section of Allergy, Department of Medicine, University of Maryland School of Medicine.)

A brief discussion, an attempted definition, and a possible explanation of the occurrence of status asthmaticus are presented. A safe, effectual, and superior method of control used in over 50 episodes of status asthmaticus is outlined. Treatment by the aerosolization of theophylline sodium glycinate is a safe and effective procedure.

Dolgopol, Vera B.: Histologic changes in rickettsialpox. Am. J. Path. *24:* 119-133, Jan. 1948.

(From the Pathologic Laboratories of the Willard Parker Hospital, New York.)

A new rickettsial disease was recognized in New York in July 1946. Biopsies of skin were made on 6 patients and a lymph node was excised in one case. These cases are reported and the condition is described. The histological examination of a skin lesion may help in securing earlier confirmation of the diagnosis.

Thomas, Carmen C., and **Hardy, Marjory K.:** Bullous skin eruptions following sulfonamide administration. J. Am. M. Women's A. *3:* 1-3, Jan. 1948.

(From the Department of Dermatology and Syphilology of the Woman's Medical College of Pennsylvania, and the Hospital of the Woman's Medical College of Pennsylvania.)

Case reports of 5 female patients with severe cutaneous, mucous membrane, and constitutional effects following sulfonamide therapy are presented and analyzed. In every instance clinical signs of drug intolerance were preceded from 36 to 24 hours by a definite elevation of temperature. Treatment with the antihistamine group of drugs appears to produce rapid symptomatic improvement.

Taylor, Ann Gray: Obstetrical risks. J. Am. M. Women's A. *3:* 4-5, Jan. 1948.

(From the Department of Obstetrics, Woman's Medical College of Pennsylvania.)

General discussion.

Birch, Carroll LaFleur: Tropical Medicine (continued). J. Am. M. Women's A. *3:* 6-13, Jan. 1948.

Guy, May Borquist: Recent advances in pediatrics. J. Am. M. Women's A. *3:* 14-18, Jan. 1948.

The topics discussed in this paper are: developmental pediatrics, immunization, diseases of the newborn period, new syndromes, new drugs, and antibiotics.

Weed, L. A. and **Parkhill, Edith M.:** The diagnosis of histoplasmosis in ulcerative disease of the mouth and pharnx. Am. J. Clin. Path. *18:* 130-140, Feb. 1948.

(From the Section on Bacteriology and the Section on Surgical Pathology, Mayo Clinic.)

Seventy-three case reports from the literature are briefly summarized and four additional cases are reported. Authors conclude that the clinical manifestations may vary extensively; that on biopsy organisms may be present in sufficient numbers to warrant a histologic diagnosis or so scarce as to render an etiologic evaluation impossible. When present Histoplasma capsulatum may be easily isolated by inoculating the emulsified tissue on to blood agar containing 50 units each of penicillin or streptomycin per cubic centimeter of medium to inhibit bacterial growth. Medium is also suitable for other agents, viz. Blastomyces dermatitidis, Coccidioides immitis, Cryptococcus hominis, and others.

Cox, Nancy: Cardiac murmurs in infancy. Brit. M. J. *1:* 148-150, Jan. 24, 1948.

(From the Institute of Social Medicine, Oxford.)

In a routine periodic examination of the heart in 630 infants, systolic murmurs were detected in 32 (5%). In 22 cases murmur was not detected until the age of 9 months or later. With the exception of one case in which a thrill subsequently developed in the pulmonary area, and another in which there was some suggestion of dyspnea on exertion, no associated symptoms or signs were recorded. No correlation between clinical findings and radiographic appearances could be established.

Warren, Marjory W.: The evolution of a geriatric unit. Geriatrics *3:* 42-50, Jan.-Feb. 1948.

(From West Middlesex County Hospital, Isleworth, England.)

The processes leading to the establishment of a 200-bed geriatric unit in a general Public Health Hospital, its development, growth, and administration, as well as the future plans of the unit, are discussed.

Rawson, R. W., **McArthur, Janet W.,** Brown, M. D., Fluharty, R. G., and Cope, O.: The functional activity of thyroid tumors, benign and malignant, as gauged by their collection of radioactive iodine. West. J. Surg. *56:* 82-95, Feb. 1948.

(From the Thyroid Clinic of the Massachusetts General Hospital, Departments of Medicine and Surgery of the Harvard Medical School, Boston, and the Radioactivity Center of the Department of Physics of the Massachusetts Institute of Technology, Cambridge.)

From these studies it appears that the capacity of benign tumors of the thyroid to collect radioactive iodine can be correlated with the degree of differentiation observed on histologic examination. There seems to be a spectrum of activity with the undifferentiated tumors at the low functional end, intermediate and well differentiated tumors in the midspectrum, and hyperplastic adenomas at the functioning end. Five of twelve carcinomas of the thyroid were observed to collect minimal but measureable amounts of the radioactive iodine. This same degree of function was found to exist in the metastases from eight of these tumors.

The fundamental function of this unique function of the thyroid tissue is discussed.

Venning, Eleanor H.: Evaluation of adrenal cortical function in man. M. Clin. North America, pp. 89-96, 1948 (January).

(From McGill University Clinic, Royal Victoria Hospital, Montreal.)

The methods in use for the evaluation of adrenal function have been reviewed with special emphasis on the measurement of urinary glycogenic corticoids as a means of determining disturbances in the carbohydrate function of the adrenal.

Radnót, Magda: Über das flache Sarkom der Aderhaut [Flat sarcoma of the choroid]. Ophthalmologica *114:* 409-414, Dec. 1947.

(From Universitäts-Augenklinik Budapest [University Eye Clinic, Budapest].)

Two cases of flat sarcoma of the choroid occurring among 53 cases of uveal sarcoma are described. The flat sarcoma perforates the sclera in many places since it is in contact at more places with ciliary vessels and nerves than circumscribed tumors. In both cases the sclera ruptured before increased tension occurred. These tumors do not show the usual stages of the clinical picture. The first case showed a highly pigmented polymorph cell sarcoma, the second a spindle cell sarcoma.

Pacella, B. L., **Kopeloff, Lenore M.,** and Kopeloff, N.: Electroencephalographic studies on induced and excised epileptogenic foci in monkeys. Arch. Neurol. & Psychiat. *58:* 693-703, Dec. 1947.

(From the Departments of Experimental Psychiatry and Bacteriology, New York State Psychiatric Institute and Hospital.)

The present study is concerned with more detailed observations regarding the time relation between electroencephalographic evidence of primary and secondary foci and the onset of convulsive seizures. In addition, the effect of ablation of the "active" focus was investigated.

Hellebrandt, Frances A.: The organization and administration of a physical medicine department. South. M. J. *41:* 66-70, Jan. 1948.

(From the Baruch Center of Physical Medicine, Medical College of Virginia.)

Every community has within it a pool of acutely ill, chronically disabled, and vocationally handicapped individuals, whose recovery would be expedited by judicious use of physical medicine and rehabilitation. It is, therefore, the responsibility of every hospital to give consideration to the problems involved in establishing the urgently needed auxiliary medical services which have demonstrated themselves to be advantageous in the attainment of the maximal functional restoration of the patient. Multiple, voluntary, State, and Federal agencies now exist for the purpose of purchasing all types of medical care, which will hasten recovery and render the handicapped self-sustaining.

Hellebrandt, Frances A., Skowlund, H. V., and Kelso, L. E. A.: New devices for disability evaluation. I. Hand, wrist, radioulnar, elbow, and shoulder ergographs. Arch. Phys. Med. *29:* 21-28, Jan. 1948.

(From the Baruch Center of Physical Medicine, Division of Clinical Research, Medical College of Virginia, and the Electrical Laboratory, School of Engineering, University of Wisconsin.)

Preliminary trial of these instruments suggests that work tolerance may be estimated with greater accuracy ergographically than by judgment of the examining physician and that ergography may be clinically useful in disability evaluation because it provides a simple quantitative tool by virtue of which the following measurements may be made: (1) initial functional capacity; (2) progress under treatment; (3) the end point of effective rehabilitation; and (4) the degree of residual disability.

Hellebrandt, Frances A.: The law of agency in the practice of physical medicine. Its educational implications. J. Am. M. Coll. *22:* 359-361, Nov. 1947.

(From the Baruch Center of Physical Medicine, Medical College of Virginia.)

Supervision of the acts of the individual to whom the physician has delegated power is implied in the law of agency, and the physician is held liable for the acts of his agent. The time has probably come for medical schools to examine into ways and means of correcting the untenable position of the average physician in the rational practice of modern physical medicine with its dependence on detailed knowledge considerably in excess of that included in undergraduate curricula.

If the physical medicine centers develop as fundamentally as signs now indicate the correction of defects will follow automatically in the sphere of medical education. In the interim, which will be long, schools might profitably attempt to assess their responsibilities in the overall planning of technical education.

Hellebrandt, Frances A., and **Duvall, Ellen Neall:** Responsibilities of the medical school in the training of physical therapists. J. A. Am. M. Coll. *23:* 44-56, Jan. 1948.

(From the Baruch Center of Physical Medicine, Medical College of Virginia.)

This paper objectively considers the problems produced by the rapid development of, and interest in the rehabilitation of the disabled, and the emergence of physical therapy as a field of endeavor demanding professional status. These must be faced if physical medicine is to take its place as a specialty of maximum benefit to those needing its services. Conclusions are drawn from these considerations and from the evidence set forth in the paper.

Jacoby, J. J., Geiling, E. M. K., and **Livingstone, Huberta M.:** Intravenous nitrous oxide and experimental embolism. A preliminary report. Anesth. & Analg. *27:* 13-24, Jan.-Feb. 1948.

(From the Departments of Surgery and Pharmacology, University of Chicago.)

Nitrous oxide was administered intravenously to 15 dogs in a total of 42 experiments. The procedures are described and the results are discussed and summarized. A brief history of intravenous administration of a gas is given.

Apgar, Virginia: A nerve block clinic. Anesth. & Anal. *27:* 49-54, Jan.-Feb. 1948.

Under the impression that many ambulatory patients were sometimes being denied the benefit of nerve blocks and in order to afford more blocks for instruction of residents, a nerve block clinic was initiated in the Vanderbilt Clinic, the outpatient department of the Presbyterian Hospital. The problems, types of cases treated, and results are discussed, and the procedures and modifications are described.

BOOK REVIEWS

(EDITOR'S NOTE:—*These reviews represent the individual opinions of the reviewers and not necessarily those of the members of the Editorial Board of this* JOURNAL.)

DISEASES OF METABOLISM: Detailed Methods of Diagnosis and Treatment; A Text for the Practitioner. Edited by Garfield G. Duncan, M.D., Director of Medical Division, Pennsylvania Hospital; Clinical Professor of Medicine, Jefferson Medical College, Philadelphia. 2nd edition. 1045 pages, with 167 figures. $12.00. W. B. Saunders Company, Philadelphia and London, 1947.

This second edition of Diseases of Metabolism is, like the first, a collaboration of the work of several writers who are authorities on the subject and is edited by Dr. Garfield G. Duncan, who has himself contributed several chapters.

The authors have presented an appraisal of the most recent investigations of chemical and physiological research and knowledge of the complicated problem of metabolism.

Carbohydrate, protein, liquid, and mineral metabolism are discussed in separate chapters with their clinical implications, including etiology and treatment. The mechanisms of water balance and acid-base equilibrium are discussed and applied to kidney diseases, heart failure, shock, pneumonia, and other conditions.

Obesity and undernutrition, vitamins and avitaminoses, hyperinsulinism, gout, and disorders of the thyroid gland are presented with much practical application for the physician. Dr. Duncan has contributed chapters on diabetes mellitus, hyperinsulinism, and diabetes insipidus. They are full, clear, and contain case histories, illustrative material, and consideration of all of the complications of these diseases.

In addition, Dr. Duncan has provided most helpful diet lists with a readily usable list of foods with their caloric and vitamin values expressed in terms of household measurements.

—Marion E. Manter, M.D.

HISTORY OF MEDICINE. By Cecilia C. Mettler, A.B., Ed.B., A.M., Ph.D., late Assistant Professor of Medical History, University of Georgia, School of Medicine, and late Associate in Neurology, College of Physicians and Surgeons, Columbia University. Edited by Fred A. Mettler, A.M., M.D., Ph.D., Associate Professor of Anatomy, College of Physicians and Surgeons, Columbia University. 1215 pp., 16 illustrations. Price: $8.50. The Blakiston Company, Philadelphia and Toronto, 1947.

This book is arranged according to subjects and brings the history of the divers main branches or specialties of medicine in separate chapters. Dr. Mettler's work includes many unusual features and gives evidence of painstaking efforts to provide a minutely documented presentation. Most of the more than 2800 footnotes to the various chapters carry references to pertinent authoritative books or papers of historical interest. Dates of birth and death are given for almost every individual mentioned. In addition, numerous extensive quotations from original sources, including many translations from Greek, Latin, and Arabic authors, are included in the text. Each chapter is furthermore provided with a bibliography of "selected readings."

Here and there this reviewer is inclined to disagree with the evaluations and opinions of the author. Concerning ancient Greek thought, for instance, the significance of the doctrine of Heraclitus appears to lie rather in the concept of eternal flux and change than in the view "that fire was the fundamental constituent of the cosmos," which is all the author states about that versatile thinker. The strong influence of Heraclitus on some of the books in the Corpus Hippocraticum (Nutriment and Regimen I) would seem worthy of mention.

As regards the Modern Period, this reviewer misses **inter alia** a discussion of such important figures as P. Flechsig, L. Edinger, and L. P. Gratiolet (brain anatomy), C. Gegenbaur and R. Owen (comparative and general anatomy, homologies), Th. Boveri and O. Hertwig (cytocentrum, fertilization), G. Mendel (genetics), and G. Bizzozero (pathology). These omissions seem the more conspicuous since many names of much less significance are included.

The superiority of a presentation by specialized subjects rather than on a broader historical base is certainly debatable but there can be no doubt that the author's approach has its merits and that a vast material has been laboriously and successfully covered in the present volume.

Modern and comprehensive American or foreign texts on the history of medicine are not numerous and thus all those interested in this fascinating subject will welcome the late Dr. Cecilia Mettler's stimulating contribution.

—Hartwig Kuhlenbeck, M.D.

CONGENITAL MALFORMATIONS: A Study of Parental Characteristics with Special Reference to the Reproductive Process. By Douglas P. Murphy, M.D., F.A.C.S., Assistant Professor of Obstetrics and Gynecology and Research Associate in Gynecean Hospital Institute of Gynecologic Research, University of Pennsylvania. Pp. 127. Price $5.00. 2d edition. Philadelphia, J. B. Lippincott Company, 1947.

This book attempts to determine the parental background of congenitally malformed children with the particular aim in view of predicting the chances for normal offspring in such families.

The first part is a report of a follow-up study on families of malformed live born children. It was found that the chances of other malformed children being born to the same parents was 25 times as great as in the general population. This, plus other observations, leads the author to conclude that "gross, human, congenital malformations arise solely from influences which affect the germ cell prior to fertilization."

Part two deals with two different groups of families with congenitally deformed children—those whose mother had had pelvic irradiation with x-ray or radium; and those whose mother had had rubella. The frequent reports in the recent literature concerning the frequency of congenital defects following rubella in the pregnant mother has stimulated investigation as to the influence of other injections and varied environmental factors on the development of malformations. Such studies require times and painstaking evaluation of properly gathered statistics.

This book should be of interest particularly to those doing obstetrical practice as it is with the obstetricians that the chances for prevention of deformities lie.

—Lois Hammond, M.D.

Medical School News

EVA F. DODGE, M.D., *Editor*

University of Arkansas School of Medicine
Little Rock, Arkansas

Washington University School of Medicine

Washington University has seven senior, nine junior, thirteen sophomore, and eight freshman women out of a total enrollment of three hundred and fifty students.

The senior women have received the following internships:

Sarah Arpe, Hospital for Women and Children, San Francisco, California; Helen Ackerman, Bellevue Hospital Medical Service, Columbia Unit, New York; Betty Brukhardt, Coney Island Hospital, Brooklyn, N. Y.; Helen Clark, Barnes Hospital Ward Medical Service, St. Louis, Mo.; Ruth Kauffman, St. Luke's Hospital, St. Louis, Mo.; Wanda Lamb, Northern Permanente Foundation Hospital, Vanport, Oregon; Patricia O'Neal, Iowa State University Hospital, Iowa City.

Syracuse University College of Medicine

There are thirty women students at Syracuse University College of Medicine. All are members or pledges of the Lambda Chapter of Alpha Epsilon Iota sorority. There are four veterans among them—two Waves and two Wacs.

In November the women of Alpha Epsilon Iota presented as their guest speaker, Dr. Hattie Alexander of the College of Physicians and Surgeons, Columbia University, and Babies Hospital New York. Dr. Alexander is well known for her work on the diagnostic principles and therapy of *H. influenzae* infections, particularly in children, utilizing serological typing methods and antiserum therapy with and without antibiotics. The topic of her lecture at Syracuse was "Present Concepts of the Treatment of *Hemophilus influenzae*.

Dalhousie University Faculty of Medicine, Halifax, Nova Scotia

Two women graduates of Dalhousie in 1944, Dr. Adelaide Flemming and Dr. Jean MacDonald, have opened offices in Halifax. Dr. Flemming has been away doing post graduate work in pediatrics and is practicing in pediatrics only. Dr. MacDonald has done one year in a Tuberculosis Sanatorium and two years in obstetrics and gynecology. She has opened her office for general practice. Dr. Flemming is on the staff of the Medical School and teaches second, third, and fourth year students.

University of Buffalo School of Medicine

The women of the University of Buffalo School of Medicine organized a society of its women medical students and women doctors, at the beginning of this school year. Frances Abel, a junior, was elected president.

The first official dinner meeting was held in November with Dr. Samuel Sanes as the guest speaker. A discussion of Dr. Elizabeth Blackwell was followed by an illustrated lecture on forensic medicine.

Flossie Cohen transferred from the University of Calcutta School of Medicine, India, to the Sophomore Class.

Boston University School of Medicine

Dr. James M. Faulkner has been appointed Dean of the Boston University School of Medicine. Dr. Faulkner was formerly Professor of Medicine at Tufts Medical School and has served in the U. S. Navy with the rank of Captain. His clinical interests lie in the field of cardiology.

The Junior curriculum of 1947-1948 includes a course given for the first time at Boston University, in which Dr. Sidney Licht is offering a very enlightening and practicable series of lectures in physical medicine. Dr. Licht is Chief of Physical Medicine and Medical Rehabilitation for the Veterans Administration in New England.

Dr. Leona Norman ('44) has been appointed associate in Surgical Research at Boston City Hospital with Dr. D. E. Harken, who is working under the Charlton Grant Fund.

Dr. Seda Sparling ('44) is Associate Pathologist to the Burbank Hospital in Fitchburg, Mass., to the Henry Heywood Memorial Hospital and to the Baldwinville Hospital in Gardner, Mass.

Rachel Boone ('49) has been elected president of the Gregory Society (the women's society for medical students at Boston University). She has recently earned the honor of the highest grade in the National Board Examination in Biochemistry.

June Jackson ('49) has been elected president of the Boston University Chapter of the Association of Interns and Medical Students, which has been in existence for only eighteen months.

Cornell University Medical College Alumni Association, Inc.

Cornell University Medical College celebrates its Fiftieth Anniversary this year. Alumni Day was held on March 11th. The program included luncheon at the Nurses Residence, followed by the business meeting and a schedule of rounds and conferences in all departments. Dinner was served, with dancing concluding the day.

Woman's Medical College of Pennsylvania

Founders' Day ceremonies were held at Woman's Medical College on Thursday, March 11, when a bust of Dr. S. Josephine Baker, founder of the Bureau of Child Hygiene, Department of Health, City of New York, in 1908, the first of its kind in the world, and Director of the Bureau until 1923, was presented to the College by Miss I. A. R. Wylie, the English writer. Miss Wylie was a friend and intimate associate of Dr. Baker until the latter's death in 1945. The sculptor is Jane Wasey of New York, some of whose work is on permanent exhibition at the Pennsylvania Academy of Fine Arts. Dr. Baker was a former President of the American Medical Women's Association, a consultant of the Children's Bureau of the United States Department of Labor, and a lecturer on child hygiene at Columbia and New York Universities. At the exercises Dr. Leona Baumgartner, present Director of the Bureau of Child Hygiene, New York, was the guest speaker. Miss Wylie made the presentation, and Dr. Louise Pearce, President of the Woman's Medical College, accepted the gift on behalf of the College.

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The Woman's Medical College of Pennsylvania announces a new cancer teaching program, made possible by funds totalling approximately $25,000, granted by the National Cancer Institute of the United States Public Health Service, to be begun in July of this year under the direction of Dr. Isabella H. Perry of California.

The field of cancer and its prevention has been a major interest of the College for many years, as witnessed by the work of Dr. Catharine Macfarlane, renowned for establishing the first clinical research in Philadelphia upon the control of cancer. This new program will make possible the expanding of the present tumor clinic into a detection and diagnostic clinic to stress various aspects of cancer, which will be especially valuable for integrating professional training and undergraduate teaching. Dr. Perry, herself a graduate of Woman's Medical College, class of 1921, now on leave of absence from the University of California Medical School, where she is the Assistant Professor of Pathology, has had wide experience in the initiation and direction of such cancer teaching programs. She has done extensive study also in aspects of endocrine influence upon tissues. Moreover, her practical knowledge of tumor registry methods will be invaluable.

As Assistant Director, Dr. Perry will have Dr. Mildred C. J. Pfeiffer, member of the faculty of Woman's Medical College, Department of Medicine, with special training in public health and in gastro-enterology.

The Woman's Medical College was founded in 1850 for the medical education of women. It was the first College to be so founded, and today after ninety-eight years of service, is the only College on this continent solely for the training of women in medicine.

* * *

A dinner was held recently in honor of Dr. Catharine Macfarlane of the Woman's Medical College of Pennsylvania in recognition of her completion of fifty years of medical achievement. Colleagues and friends gathered to salute Dr. Macfarlane, who, even with fifty successful years behind her, is not content to rest on her accomplishments. She is still working vigorously to conquer the never-ending problems facing her in her practice.

Dr. Macfarlane's name has become almost synonomous with cancer detection and prevention in Philadelphia and throughout the country. Hers was the first research in the city on the need for early cancer detection.

Representatives from all the Philadelphia medical colleges, from leading medical organizations, physicians, civic leaders and friends were present to pay tribute to Dr. Macfarlane and her work. Dr. Edward L. Bortz, President of the American Medical Association, and Judge Dorothy Kenyon, U. S. delegate to the U. N. Commission on Status of Women, were the principal speakers.

Dr. Macfarlane was charming and witty in her reminiscences of her early practice. When she opened her first office fifty years ago, one Philadelphia physician to whom she paid her respects was so flustered when confronted by a "petticoat" doctor that he could think of nothing but the advice he usually gave young men doctors: "Open your office on the main street, don't drink and you'll be a success."

Whether or not the advice was a motivating factor in her success, Dr. Macfarlane's half century of eminent achievement is a notable record that, with her indomitable energy and spirit, will undoubtedly be prolonged for many more years.

News of Medical Women

NEWS NOTES FROM CLEVELAND

Cleveland has just successfully completed a campaign for nine and one-half million dollars for hospital building. Twelve hospitals are to be aided, two of them new hospitals to be built in outlying areas where the need is great, while others are to be given new wings or repaired. The first project will be an entire new building for the Woman's Hospital to be built on land owned by the hospital adjacent to the present buildings. The fund will provide 50 per cent of the estimated cost of the one hundred twenty-five bed hospital. Working drawings are now under way and it is hoped construction will be started in the early fall.

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Dr. Emmy Katan and her husband, Dr. Maurits, have been in Cleveland for eighteen months. They are associated with the Psychiatric Department of Western Reserve University Medical School in training psychoanalysts. They received their medical training and analytic training in Vienna and practiced there. Dr. Elizabeth Bremmer has recently joined the same Department as child psychiatrist.

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Dr. Janet Dingle recently became a Diplomate of the American Board of Internal Medicine; she is the school physician at Laurel School, a private school near Cleveland. Dr. Lorna Spenzer has accepted a full time position in the Health Department of Cleveland Public Schools. Dr. Frances Pickett, Dr. Faith Reed, and Dr. Emilia Nitsch are also physicians in the public school system. Dr. Elizabeth Endicott and Dr. Dorothy Hicks are associated as school physicians in the Shaker Heights schools.

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Dr. Faith Reed was a delegate from the Cleveland Maternal Health Association to the National Council of Family Health Relations. The meetings were held in December in New York.

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Dr. Leona Glover was a delegate from Cleveland to the Planned Parenthood Association Annual Meeting in New York in February. She is School Physician at Hathaway Brown School, a private school for girls, and has also been working long hours as associate editor of the Blakiston-Gould Medical Dictionary which will reach the bookstores, it is planned, in early September. Since 1928 Dr. Glover has served in varying capacities in the Health Department of the Shaker Heights Public Schools. She resigns this year as Instructor in Hygiene. These activities have been conducted while Dr. Glover has been busy as a home maker for her husband and four children. There is now a small grandson added to the family. Her husband, Dr. Donald Glover, returned last year after more than three years with the Lakeside Unit in Australia and New Guinea. When separated from service he was Colonel and Commanding officer of Base Hospital No. 4.

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Dr. Beulah Wells goes to Buffalo to the meetings of the American Academy of Pediatrics, and Dr. Marion N. Gibbons to the meetings of the American College of Physicians in San Francisco in April.

NEWS BRIEFS

The three-year plan for expansion of child-care services under the Social Security Act was outlined by Miss Lenroot, Chief, and Dr. Martha Eliot, Assistant Chief of the Children's Bureau, to the Senate Advisory Council on Social Security. This advisory group of citizens has been meeting in the Library of Congress for many weeks to consider recommendations for improving the Social Security Act. Dr. Florence R. Sabin, recently appointed Director of Health, Department of Denver, requested the plan for increased child services. The Council has now completed its conferences and will make recommendations to the Senate.

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Another Cancer Detection Clinic has been opened—the Tarrant County Tumor Clinic at Fort Worth, Texas, of which Dr. Helen Gottschalk is Executive Director.

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The appointment of Dr. Leona Baumgartner, Director of the Bureau of Child Hygiene, New York City Health Department, as Chairman of the maternal and child health section of the National Health Assembly, has been announced. The Assembly, held in Washington, D. C., May 1 to 4, was called as a result of a message from President Truman requesting Mr. Oscar Ewing, Federal Security Administrator, to develop national health goals that are feasible in the next ten years.

FROM DAY TO DAY

(The Chronicle of an Editor)

We have had many letters from our colleagues abroad this month. From **Czechoslovakia** Dr. DiLotti writes that "as soon as the Journal of the American Medical Women's Association is received there, it is at once circulated among the members of our Medical Association; we are planning an exhibit of medical women's activities and achievements for the exposition in Kromeriz, Monravia, scheduled for this coming summer." * * * * * We were very pleased and gratified to receive a letter from Dr. Gabriele Strecker, our correspondent in **Germany**—"The Journal arrives regularly; my husband and my colleagues enjoy reading it too—the demand for foreign publications is enormous as we have lost almost all contact with the outside medical world and we need information about what is going on in medical research. It is hard to tell you how deeply we appreciate the valuable information in your Journal—but, not only do the fine articles cause such pleasure—we also enjoy the distinguished appearance and make-up, it is such a pleasure to have such a beautiful journal at our disposal and I am honored at having the privilege of collaborating in it. . . . on January 31st, we founded in Frankfort the Society for Promoting Tolerance, the members are government officials, members of the press, etc. I am supposed to broadcast on the subject—'How to overcome women's prejudices.' As an introduction to this new program, I thought a psychological analysis of prejudice would be necessary. I translated the very good article written by Dr. Helen McLean on Group Tension in your November Journal. I think both the Journal and the article by Dr. McLean are worth quite a bit of publicity. I shall send you a translation of the first broadcast. From the description of your days in November (the January issue) your office in New York must be a little bit of a Medical United Nations. . . . If there is still some hope for the once called One World then the hope will be maintained by the noble achievements toward peaceful aims in the spirit of real international cooperation as expressed in your Journal. Let me thank you again for the privilege of receiving the Journal." * * * * * From **Finland,** Dr. Anni Seppanen writes "The Journals are very interesting indeed with their news about the Associations and members in various countries, not to speak of the amount of medical and social knowledge they contain. The Finnish Association of Medical Women is now officially registered and there are 187 members—about 65% af all the women doctors in Finland. At our October meeting the members who had attended the Amsterdam Congress spoke of their experiences. We all felt that the opportunities we had last summer to become acquainted with women physicians from other countries had proved for us very valuable. Dr. Eriksson—Lihr was elected a member of the City Council in Helsinki last December. We are arranging—with other women's organizations, a course of lectures for public and secondary school teachers on the problems of sex education." * * * * * In a letter from **Holland,** Professor Ruys writes: "Each month when receiving the Journal of the American Medical Women's Association, I read it with very great interest, not only the medical articles but also the news."

It is very gratifying to learn from these letters that our colleagues in other lands find our Journal of value—and of interest.

The long awaited book, "Women Doctors at Work During the Second World War," has now arrived from **Sweden.** It was compiled by Dr. Andrea Andreen from papers presented at the Medical Women's International Association meeting in London in September, 1946, and is a most interesting account of the work of the women physicians and surgeons in the Forces and in the Resistance movement. This is the book which we previously announced in the Journal would be available for one dollar ($1.00), but Dr. Andreen writes that because of greater cost of production, it has been necessary to raise the price to one dollar and fifty cents ($1.50). Will all those of you who want a copy of this pamphlet send check for $1.50 to Dr. Ada Chree Reid, 1 Madison Avenue, New York 10, N. Y. It will be forwarded to Dr. Andreen.

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The delegates who will come from **Sweden** to the U. S. A. this summer to celebrate the one hundredth anniversary of the large scale Swedish immigration into America's middle-west will be headed by Prince Bertil. The only woman member of the delegation (ten in number) is Dr. Nanna Svartz, Professor of Medicine at the Carolinian Institute, which annually awards the Nobel Prize in physiology. She is also head physician of the Carolinian Hospital.

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From **Italy,** Dr. Mara Polazzoli Selvini (Milan) writes that Italian women physicians held their National Congress on October 12, and elected the following officers: President, Dr. G. Pastori, Professor of Biology at the Faculty of Philosophy of the Catholic University of Milan; Secretaries, M. T. Casassa, Assistant in the Department of Hygiene, Turin University, and Elda Barengo, Assistant in the Bacteriological Laboratory of the province of Milan. Six National Counselors also were elected, one of whom is Dr. Selvini. Dr. M. Malagoli has been appointed Head of the Section of Children's Assistance of the Municipality of Milan, and Dr. A. Gatti Casazza has been named Doctor-in-chief of the Department of Physiotherapy at the Main Hospital in Milan. Those who attended the Amsterdam Congress will remember meeting Dr. Polazzoli, now Dr. Polazzoli Selvini.

* * *

The following letter recently arrived from Dr. Ada Middelhoven of **Holland:** I am very grateful that your Journal offers me another opportunity to thank the American people and particularly their medical men and women for their marvelous hospitality. In the three months of my visit to a considerable number of medical centers in the United States I tried to get a survey of American pediatrics and I had ample opportunity to study wonderful achievements in many fields of modern research. It is perfectly impossible for me to mention all the interesting and striking facts, and I must apologize to many teams of workers that I cannot honor all of them in particular. Among the achievements that impressed me most was the remarkable work done in America for the children suffering from congenital malformation of the heart. Thanks to the efforts and co-operation of the pediatricians and surgeons in the medical centers of Baltimore, Boston, and Chicago, these children can now be offered a chance to escape the fate of a life of more or less complete invalidism and sometimes of early death. Another triumph of work in thoracic surgery is the remark-

able result in the surgical treatment of newborn children with esophageal atresia who had no chance of survival until recently; most of the credit of this goes to the Boston team of surgeons. American pediatricians are struggling with many problems that are haunting us in Europe likewise, and I should like to mention particularly nephrosis in childhood and the treatment of otherwise fatal cases of tuberculosis with antibiotics and other drugs. I am convinced that the near future is going to bring about a revolution in the latter field particularly; and I feel that we in Europe, being unable to do our share in the work for lack of the necessary supplies of the drugs involved, must watch the work done in the United States as closely as possible. I sincerely hope to be spared the fate of telling parents that their child is going to die of tuberculous meningitis or miliary tuberculosis, knowing that it could have been saved in the U.S.A. I feel that making these drugs available to Europe too is going to be but a minor item of the great many tasks for European economic recovery as a whole, but certainly a most important one from a human point of view. I am grateful to have been in touch with so many aspects of American life, feeling that such contact is most useful for better international understanding. I hope to be able to keep in touch with my American friends."

* * *

The women physicians of the Scandinavian countries are planning to hold a meeting at Lillehammer (about 4 hours from Oslo) in June—reports Dr. Herdis Gundersen of **Norway.** * * * Among the physicians from Norway who attended the Pediatric Congress in New York last July were Dr. Margit Vik Larsen and Dr. Kirsten Utheim Toverud. This was Dr. Larsen's first trip to the U. S. A. and she was very enthusiastic about the Congress, the hospitals, and other institutions. She travelled quite a bit, being interested in the care of premature children; this she thought especially well managed in Chicago. Dr. Toverud is the head of one of the children's clinics in Oslo. This was her second trip and in January 1948, she made her third trip, as she had been invited to do some research in nutrition. This invitation came as a result of her lecture at the Pediatric Congress on nutritional requirements in growth. * * * Dr. Olga Imerslund, assistant doctor at the Children's Department of the State Hospital, Oslo, has written an interesting article in Acta Pediatrica (xxxiv Fasc. 4, 1947) on Familial Haemorrhagic Diathesis with Prolonged Bleeding Time (Thrombopathias). The author made investigations in three families where thrombopathias occurred as a recessive inheritance. In one of the families examined the members lived in a district in which consanguine marriages were comparatively frequent. In all cases coagulation time and prothrombin time were normal, and as a rule the number of the thrombocytes was also normal. Endogenous hemorrhagic diatheses with prolongation of the bleeding time is here described for the first time in Norway.

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A letter from Dr. Heise in **Denmark** reports that Dr. Ytting has arrived home after several months in the U. S. A. She was invited to remain in New York to do research but felt she should return to her work in Copenhagen.

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Professor Ruys of **Holland** arrived May 6, in New York, travelled to Washington May 9 for the International Congress on Tropical Medicine (May 10 to 20) at which she gave a paper; visited Baltimore and Philadelphia on the way back, talked to the students of the Woman's Medical College of Pennsylvania, May 21, arrived in New York May 22, and left for Holland on May 25.

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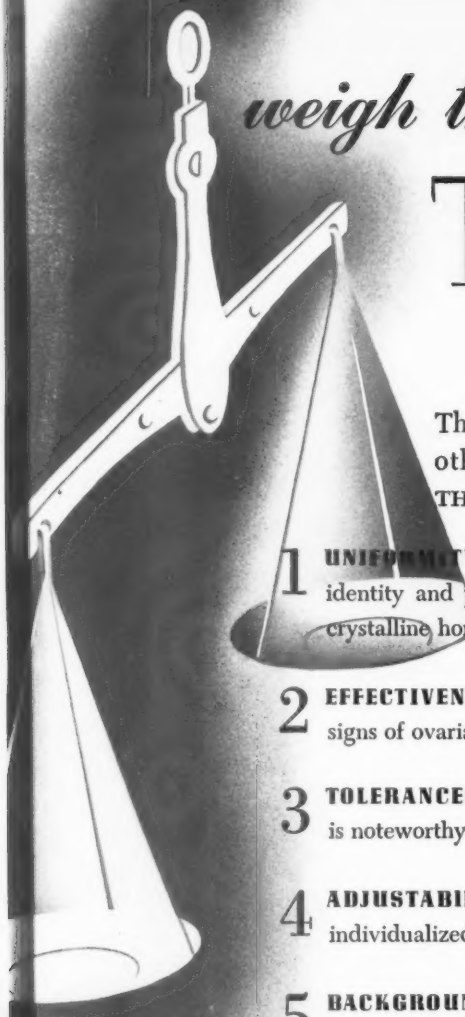
From **India** comes the annual report (1946) of the American Baptist Mission Hospital in Gauhati, Assam, of which Dr. Mary E. Kirby is the Director. She tells of their conversion from war to peace-time service—the hospital in-patient and the clinic census have more than doubled. These figures speak louder than words in showing the growth which has taken place in the hospital work. Dr. Kirby is a graduate of Temple University Medical School, Philadelphia, 1942, and took up her work in India in the fall of 1944 with Dr. Alice Randall. Dr. Randall has now retired so that Dr. Kirby is in great need of a young woman physician to help with the work. Says Dr. Kirby: "The opportunities are boundless and we are faced with a real challenge to match the interest that is being shown by the Indian people in this community."

* * *

We have had a most interesting visit with several women physicians from **China** here on World Health Organization Fellowships. Dr. Mabel Gardner, our President, was in town and with Dr. Esther Lovejoy joined us for lunch at the Women's City Club. Our guests were Dr. Marion Yang, Government head of all Maternal and Child Welfare; Dr. H. H. Huang, Director of the Sinza Health Demonstration Center in Shanghai; Dr. Jeanette Lin, Director of the Maternity and Child Health Center of Shanghai; and Dr. Yun Yu Ku of Chungking, associated with the Mass Education Movement. Her task is the simplification of the Chinese language and she has been able to reduce the number of characters from over 40,000 to about 1,300. Many women physicians in China have "top" appointments in the government services, in hospitals, and in educational institutions. Dr. Yang reports "there is no discrimination now in China because physicians, both men and women, are so greatly needed."

* * *

At the **United Nations,** Lake Success, and lunched with Mme. Amanda LaBarca, chief of the Secretariat for the Commission on the Status of Women, and Miss Marie Ginsberg of the Staff of Interpreters. Mme. LaBarca knew many women physicians of Latin America, as she comes from Chile. From her we learned that the first women physicians of South America were Dra. Eloisa Diaz and Dra. Ernestina Perez, who graduated from the University of Chile School of Medicine in 1877, in the same class. * * * At the United Nations that afternoon the Soviet Union announced it had ratified the constitution of the World Health Organization, the twenty-fourth member of the United Nations to become a full party of the agency. Before the WHO can become a fully operating agency of the U. N. twenty-six countries must become members. France has taken steps to bring that country into membership. If that happens, it will leave the United States as the sole major power that has not ratified the WHO charter. As this seemed to us an undesirable position in which to find ourselves, we investigated our present status in respect to ratification. We found that the Senate approved membership last summer, but that the Rules Committee of the House of Representatives on March 12 had secretly tabled a bill to that effect, so that the United States will not become a member for the time being. We sincerely hope that by the time these notes are read, the Rules Committee will have rescinded their action for without the United States, the WHO will have to curtail much of the work already begun.—**A.C.R.**



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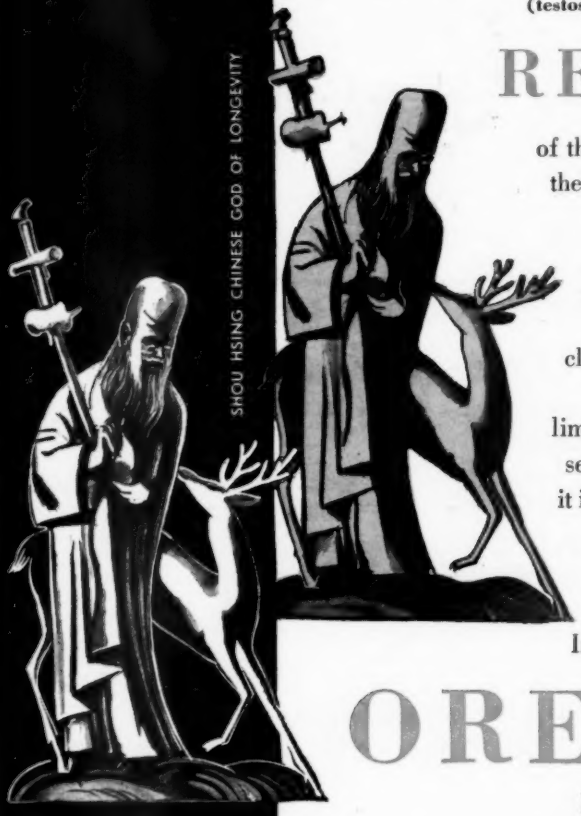

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Bibliography: (1) McCullagh, E. P., and McGurl, F. J.: Endocrinology **26**:377, 1940. (2) Thompson, W. O., and Heckel, N. J.: J.A.M.A. **113**:2124, 1939. (3) Goldzieher, M. A.: Geriatrics **1**:226, 1946.

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